Regional Oral History Office
The Bancroft Library

University of California
Berkeley, California

Kaiser Permanente Medical Care Program Oral History Project

Sam Packer, M.D.

HISTORY OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

An Interview Conducted by
Malca Chall
1986

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SAM PACKER, M.D.

Photograph by Elson-Alexandre
Los Angeles

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PREFACE

Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield and a handful of young doctors, whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers as well as the workers themselves.

During World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again

at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington and Portland, Oregon. The Kaisers would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven in the organization's own medical offices and hospitals the health plan's value in offering quality health care at a reasonable cost. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values and, despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded thoughout the nation. In September, 1945, the Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was, who would control the health plan--management or the doctors? Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Capener, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

By mid-1985 an additional ten had agreed to participate. They are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, and Berniece Oswald.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program. Similarly the project lost Karl Steil due to his lengthy illness and death in 1986.

The advisory committee suggested 1970 as the approximate cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is located at the end of the volume.

To gain additional background material for the interviews, the staff talked to five Kaiser Permanente physicians in northern California, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist*, Ephraim Kahn*, James Smith*, and William Bleiberg*. James De Long* in Portland, and William Green*, William Allen*, and Dr. Toby Cole* in Denver talked about the history of their regions. In addition, Peter Morstadt*, formerly executive director of the Denver Medical Society discussed the attitude of the Medical Society toward Kaiser Permanente's years in Denver.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews with the first nine pioneers took place between February and June, 1985, and with the second group between February and December, 1986. The transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound. The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's participation in and observation of significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and

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*Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.

businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the individual and organizational achievements that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to the development of the West. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

23 January 1987
Regional Oral History Office
Berkeley, California

INTERVIEW HISTORY

In 1969, when the Ohio Kaiser Permanente Medical Care Program was established in Cleveland, Dr. Sam Packer was elected president and medical director of the medical group, a position he held until 1983.

Packer's general commitment to the success of prepaid group health care had already been tested. In 1964 he left a successful fee-for-service practice in general surgery to become a founding member and chief of surgery with the Cleveland-based Community Health Foundation. Finding he liked the idea of prepaid medicine and the opportunity to practice without the need for the entrepreneurship required of solo practice, he stayed on the medical staff when the Community Health Foundation merged with the Kaiser organization in 1969.

The Community Health Foundation had been established in 1964 with strong labor backing. Under the influence of Dr. Ernest Saward, then medical director of Kaiser Permanente's Oregon region, and Avram Yedidia, long time consultant in prepaid medical care for Kaiser Permanente, it had been modeled after the Kaiser Permanente medical program on the West Coast. A number of unexpected factors slowed membership growth and ultimately, in order to retain prepaid medicine in the Cleveland area, foundation management and representative labor leaders turned to the Kaiser Permanente Foundation Health Plan/Hospitals for assistance.

At that time key personnel of the Kaiser hospitals/health plan and Permanente physicians realized that by expanding their boundaries from California and Oregon to Cleveland and Denver (also seeking a prepaid program), they had an opportunity to demonstrate that the health plan could be successfully transplanted into other areas of the United States. They agreed to take over the foundation, and assigned the Northern California Health Plan management and Permanente Medical Group to sponsor and advise the Ohio region.

The merger took place in January 1969. In April Sam Packer was elected medical director. Dr. Packer's experience as medical director for the following fourteen years of the Ohio region's growth forms the basis for this perceptive oral history. Although Dr. Packer, by his own admission, has always been willing "to speak out about matters others may tolerantly accept or do battle with in other ways," he had paid no attention to the management side of the issue during the four difficult struggling years of the Community Health Foundation. Thus, his election as CEO of the medical group came to him as a shock. In the ensuing years he learned about budgets, rate setting, FTEs, and getting along with the management team, but never relinquished his part-time position as a surgeon. As might be expected of someone who minored in English, Dr. Packer speaks clearly and easily. He also spoke candidly, following the outline for the interview, and adding considerable detail as he looked back upon his career as medical director.

Sam Packer, the seventh and youngest son in a Cleveland family, completed high school in 1933 during the midst of the Great Depression. Determined to go to college, in 1936 he enrolled in night school at Cleveland College, first studying English and later switching to science after he decided to go to medical school and become a psychiatrist. Six years later, A.B. degree in hand, he applied to Western Reserve medical school, but was not accepted. Almost at once he was drafted into the army, where he remained until 1946.

Returning to Cleveland, he entered Western Reserve University School of Medicine under the G.I. Bill. He soon lost interest in psychiatry, his concern having been retardation, not Freudian analysis. Upon graduation in 1950 and completion of a year's internship at Valhalla, N.Y., he returned to Cleveland and took up residencies in surgery. Along the way he married a medical school classmate who specialized in pediatrics--valuable background for the parents of five children.

We sat in Dr. Packer's office in St. Anne's Medical Clinic for the interview on May 8, 1986, which lasted nearly five hours. During lunch, brought from the clinic cafeteria, we turned off the tape recorder and purposely talked about subjects other than the medical program, primarily about Dr. Packer's children and their careers. While reviewing his transcript Dr. Packer made minor revisions to clarify his meaning and ensure the correct spelling of names and medical terms.

This oral history and that of Bill Reimers provide insight into the problems encountered and resolved by medical directors of the Ohio and Colorado regions as they sought to achieve success for their new regions in the Kaiser Permanente Medical Care Program.

Malca Chall
Interviewer-Editor

10 February 1987
Regional Oral History Office
486 The Bancroft Library
University of California at Berkeley

CURRICULUM VITAE

NAME:	Sam Packer, M.D.
ADDRESS	2845 North Park Boulevard Cleveland Heights, Ohio 44118
TELEPHONE:	371-5334
BIRTHDATE:	October 8, 1915
MARITAL STATUS:	Married - 5 children
PRE-MED EDUCATION:	Cleveland College Cleveland, Ohio A.B. - 1942
MILITARY SERVICE:	Army of United States November 1942 - March 1946 Progression from Private to 1st Sgt. in Combat Engineer Battalion
MEDICAL SCHOOL:	Western Reserve University School of Medicine - M.D. 1950
INTERNSHIP:	Grasslands Hospital Valhalla, New York 1950-1951
RESIDENCIES:	Crile V. A. Hospital Cleveland, Ohio General Surgery 1951-1953 St. Vincent Charity Hospital Cleveland, Ohio General Surgery 1953-1955
HOSPITAL STAFF APPOINTMENTS:	Kaiser Foundation Hospitals University Hospitals of Cleveland St. Vincent Charity Hospital, Cleveland, Ohio
TEACHING APPOINTMENTS:	Case Western Reserve University Cleveland, Ohio Senior Clinical Instructor, Surgery 1956-1972
CERTIFICATION:	American Board of Surgery - 1956 Fellow, American College of Surgeons, 1961
LICENSURE:	Ohio #17054

MEMBERSHIPS:

Alpha Omega Alpha
American College of Surgeons
Academy of Medicine of Cleveland
Ohio State Medical Association of Cleveland

PREVIOUS POSITIONS:

Solo Fee for Service Practice, General Surgery
1955-1964

Founder Member of Community Health Foundation
Medical Group, July 1, 1964

Chief of Surgery, Community Health Foundation
Medical Group, July 1, 1964 - March 31, 1969

President and Medical Director of the
Ohio Permanente Medical Group, Inc.
April 1, 1969 to January 11, 1983

PRESENT POSITION:

Operations Consultant and
Director of Special Projects,
Ohio Permanente Medical Group, Inc.

PROFESSIONAL ORGANIZATIONS:

Member of Board of Directors
Group Health Association of America
1969-1982

Member Board of Directors
Health Care Coalition of Greater Cleveland
1979-1982

Member of Visiting Committee of Board
of Overseers, Frances Payne Bolton School
of Nursing, Case Western Reserve University
1980 to present

Chairman of Kaiser-Permanente Committee
1973-1974

Co-Medical Director
Kaiser Foundation Health Plan of Connecticut
July 1, 1982 - December, 1982

Member of various committees of
Academy of Medicine of Cleveland, Ohio

I EDUCATION: THE LONG ROAD TO MEDICINE

[Interview 1: May 8, 1986]##

Family Background

Chall: We can start with your personal history. Tell me a little bit about your family background. You say you grew up in Cleveland?

Packer: I was born here, yes. [October 8, 1915] I was the youngest of seven. Seven sons. And I was the only one who got a professional degree, which, in a sense, permitted the others to compensate through me for their failing to recognize what they considered to be their potentials.

I lived here all my life except briefly when, in 1942, I went into the army. I served in the army as a combat engineer, which is quite interesting because at that time I already was a college graduate. I believe, perhaps, my undergraduate degree is interesting, since I graduated from high school during the height of what we now call the Great Depression, in 1933, not very long after the banks had closed and when the future looked pretty generally glum.

I did not go to college directly after high school, but rather started working as much as I could during the Depression, after graduating from high school. In 1936 I began to go to night school at Cleveland College of Western Reserve University. It was a downtown school and its student body consisted, to about 90 percent, of evening students who varied in age from my age—I was in my early twenties—to people in their fifties and older who, over a period of many, many years, pursued a degree until they got one after twenty years or so by going to school one or two nights a week.

Chall: Were you studying to be a doctor at that time?

##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 78.

Packer: I had no idea what I wanted to be. Like many kids my age who graduated in the early thirties, I thought, particularly, of chemistry. Many of my high school classmates became chemists. I also liked to write, and I thought about journalism. During my first year one of my major courses—I went to night school three nights a week then--was in the English department, some kind of English course.

I went to night school, then, for six years. For the last couple of years I went to school every night of the week except Saturday and Sunday. Indeed, I believe in my second to last year I carried the equivalent of a full load, a day student full load. Meanwhile, of course, I worked in factories, by and large, to support myself and to help support my parents. I, being the youngest, the youngest of seven, you can understand my parents were not young at this point. And my father, who was a carpenter, was hit very hard by the Depression, because people stopped building houses.

At any rate, I graduated in 1942, in May of 1942, with a bachelor or arts degree and a split major. Well, actually, I majored in psychology, which may give you some idea that the shape of the future was pretty unclear to me. At that time I majored in psychology because I thought I wanted to be a psychiatrist.

I thought I wanted to be a psychiatrist because of a family circumstance. I was the youngest of seven. The brother next older to me, the sixth child, had what is now called Down's syndrome. He was very severely retarded, but was kept at home, indeed, until shortly before my mother's death in 1956. He was born around 1912, so he was forty years old then, and we kept him at home all those years. It was an enormous trial for my parents, and I was convinced that there ought to be some way of curing diseases like this, which led to my interest in psychiatry.

Chall: Nobody knew that it was--?

Packer: We didn't know anything about the etiology of mongolism then. They were called mongolian idiots, mongoloids. And the etiology was totally obscure. But it was recognized there was a relationship to pregnancy at a relatively advanced maternal age. He was number six, but then I was number seven. It sort of disputes that, somewhat

Despite that interest in psychiatry, I had four years of chemistry and a year of engineering physics at the Case Institute of Engineering across the fence on our campus. Western Reserve and Case were independent schools, side by side, separated by a fence. Physics was not offered every year at Western Reserve at night, and

Packer: the years it wasn't offered we had the opportunity of taking it at the engineering school—which really wasn't a blessing because the first year of engineering physics was much more difficult than elementary physics in the liberal arts school.

I had had a couple of years of biology, so somehow I had a good scientific background. Along with my major in psychology, I minored in English and, indeed, had gone through everything available at night in the English department, including graduate courses. With that rather unusual background for a bachelor's degree, I promptly went into the military service, in 1942.

And even more strangely, I, a city boy, who maybe had shot off a few small firecrackers, rather quickly was being identified as particularly proficient in demolitions. So I spent the next three and a half years as a combat engineer in first the 89th and then the 71st infantry division.

Chall: Where did they go?

Packer: I finally went to Europe. I went to Europe with the 71st infantry division, and I got a couple of battle stars, a bronze star and so forth. I practiced my skills as a combat engineer and sharpened my skills in demolition. I came home having achieved the high rank of first sergeant in my outfit.

It always interested me that destiny seemed to take a hand in my life because—very early—at the beginning of 1943 I was scheduled to go to OCS [Officers Candidate School] at Fort Belvoir. The need for second lieutenants in the combat engineers was very great because the losses in North Africa were enormous. The mortality rate, it was rumored, of second lieutenants in the engineers was approximately 50 percent. However, being young, and having an almost evangelistic sense of need to fight Hitler, I accepted that risk and was scheduled to go to OCS. Indeed, I got what was called an OCS furlough, which meant that after passing a physical and being interviewed at division headquarters one went home on furlough and came back to go directly to OCS where, if you survived the ninety days, you came out a second lieutenant.

Unfortunately or otherwise, when I was away we were scheduled for a major maneuver, and all leaves and all OCS transfers were canceled pending further notice. Had that not happened, I would have gone to North Africa, and might have been one of that 50 percent.

Then later that year I again went through the whole rigamarole and again was scheduled to go OCS, again was sent home on a furlough, and again came back, this time to find that we had been alerted overseas; everything had been canceled.

Packer: At that point I gave up aspirations of becoming an officer. Also by that time, like many other relatively veteran GIs, I had begun to recognize that second lieutenants really weren't very important in the eyes of many GIs.

To continue on that vein a moment, I guess I was first at Camp Carson in Colorado, and then went to Fort Benning—a large infantry post, from which we finally went overseas. While at Fort Benning I got somewhat careless in demonstrating booby traps to some infantry troops. They had pioneer companies which did some of the work for the infantry battalion that the combat engineers did on a more routine daily basis for the infantry division.

And as I say, I got carried away by my own expertise and my status as a demolitions instructor for the infantry. I got careless with a booby trap and violated one of the cardinal safety rules and had it blow up in my face. My immediate assumption was that I had lost my eyes. In a moment, in a fraction of a second, I did have, oddly enough, a kaleidoscopic review of a piece of my life, like six years of night school wasted, what for—there's no need for blind doctors.

It was just an overwhelming sense of joy that I had when I separated my fingers. I had thrown my hands over my face when I saw what was happening. I was on my belly with my head right next to the booby trap, which exploded with a pound of dynamite attached to it, enough to kill a man. But it didn't kill me. We had been told many times there was a zone of safety within a couple of feet of the explosive itself, which none of us believed. But apparently that was true. The charge was sufficient to kill a man, certainly sufficient to injure him seriously.

I was in the hospital for about ten days, with my eyes swelled shut and many small wounds—with pieces of shrapnel embedded in my face and shoulders. In spite of that, when I picked myself up I had my vision and survived to become a doctor. You asked for my personal history, and it's a little different, I believe.

Medical School and the Decision to Become a Surgeon

Packer: Now, to complete my personal history, as far as medicine is concerned. I had actually applied for admission to Western Reserve in 1941, when I had another year of undergraduate school. Perhaps immodestly, I may say that I had done extremely well, and was nearly a straight A student and was commended by important members of the faculty. I appeared to be welcomed by the Western Reserve

Packer: medical school, but the state of my finances became clear because of a questionnaire I had to fill out which asked a very silly question. It was obvious that my finances weren't particularly good since I had been working and going to night school. The dean very regretfully told me that my draft status and my financial status were problems. Well, the draft status was not. Had I been admitted I would have been exempt, of course, from the draft. Be that as it may, while I was still overseas in 1945 one of my brothers wrote and told me about the GI bill. And not only that, he went down and talked to a new dean at Western Reserve. The new dean reviewed my application, and told my brother to have me write him and indicate whether I remained interested, after four years, and if I was that he was optimistic about my chances.

I wrote the dean, knowing nothing, really, about the GI bill, and after my discharge I saw him while still in uniform, the day after I got home. He told me he had reviewed my initial application. He asked me to keep in confidence that, in his opinion, I had been discriminated against and there was no valid reason for their failure to admit me in the class of '42. He offered me an appointment. This, now, was March of 1946, when the entering class of '46 was filled. He offered me an admission immediately, if I wanted it, without taking any test again or getting letters of reference again.

Chall: Why did he think you had been discriminated against?

Packer: Well, for two reasons. I think the major reason, probably, was that financially I was technically poor, I guess.

Chall: They didn't give scholarships to medical school much in those days, did they?

Packer: If they did, I certainly knew nothing about it, and I expect they gave very few, and generally those who could afford to pay their way were getting in.

The other reason, probably, was a matter of quotas. They had a variety of quotas, and undoubtedly I fell within one of their quotas which, combined with being poor, made it impossible.

It wasn't easy, in '46, for me to make the decision to go to medical school, because after World War II and all the excitement, all the maturing I did, I wasn't sure I was ready for the sedentary life of a medical student. So I got a job in Frankfurt, Germany, to start in September of '46. I weighed the options and finally realized the practical thing was to try medical school. And if I couldn't stand it—. Well, that's how I became a doctor. It's a long and, I think, somewhat an unusual story.

Packer: As for surgery, I had no idea I wanted to become a surgeon. But I had a very good idea I didn't want to be a psychiatrist shortly after entering medical school when I was exposed to the new head of the department, Dr. Douglas Bond, a very highly regarded psychiatrist. A very articulate, interesting guy, but totally freudian. My interest in psychiatry wasn't—I found Freud interesting reading, but I really wasn't interested in freudian psychiatry. As I say, I thought I was interested in treating people like my brother, and there was absolutely no evidence of interest in that kind of illness.

I had no idea what I wanted to do in medicine. I found myself interested, finally, in everything including things I was sure I would dislike intensely. Even like obstetrics, even like ophthalmology. The only thing I never really cared for was dermatology.

So when I graduated I took a rotating internship in New York at Valhalla at Grasslands Hospital, which is now the New York Medical College Medical Center. And I went there because my wife, who was a classmate, wanted to be near home. We weren't married at that point, and I wanted to be near the girl who was going to be my wife.

Chall: She was here in Western Reserve at the medical school?

Packer: Yes, we graduated together.

I took a rotating internship. While interning my father died. Indeed, he died immediately before the internship started. My mother started to do poorly, and I felt that I wanted to come back to Cleveland to help things at home. So I began to look for a job which would support us, assuming that we would be married at the end of our internship. I interviewed at University Hospitals here, where I had done very well as a student, in surgery. I was offered a second year internship, which is equivalent to a first year residency.

But it only paid sixty dollars a month. Impractical as we were, we knew we couldn't live on that, particularly if my wife got similar compensation. And so I interviewed at the VA hospital which paid more than anyone else. It paid two hundred dollars a month. I interviewed first in medicine, and then later in surgery, and was invited by both departments.

Since we talked about, before we got married, moving to a small, idyllic town—which, of course, didn't exist—and doing the usual idyllic family practice together there, I decided that I ought to get at least a year of surgery for that practice. I didn't think that year of surgery taught me enough and I thought I

Packer: should get another year of surgery. And then I realized I now had three years towards the five years for board certification, and somehow I ended up a surgeon.

Chall: And what did your wife do? What was her specialty?

Packer: Well, my wife started training in pediatrics at Babies and Childrens Hospital here. Somehow, after we had been married about nine months, she was apprised that she was pregnant. Our first child was born approximately eighteen months after we were married and at a point which sort of destroyed, at that time, her second year of training. And so she trained piecemeal in pediatrics and did a limited practice in pediatrics because after that first pregnancy she had four more. We have five children.

Chall: That's a good-sized family!

Packer: So she is a pediatrician.

Chall: I see, so she really didn't give up medicine.

Packer: No, she never gave it up, no. She never practiced full time, but she practiced part time. Except for brief periods after each pregnancy.

Chall: But you have stayed right here in Cleveland. You didn't move?

Packer: Except for a year of internship, and except for my military service, I have spent my life in Cleveland, you're right.

Chall: And you started out, then, of course, in fee-for-service medical practice--that was about all there was.

Packer: Yes. I did not complete my training at the VA hospital because I had a major back problem and was operated on for a herniated disc in March of 1952, which interrupted that training, so that I completed my training at St. Vincent Charity Hospital here in Cleveland. And after completing my training I went into solo practice here and remained in solo practice until I was recruited into this program as one of the founder members.

II THE COMMUNITY HEALTH FOUNDATION, 1964-1968*

Getting Organized

Chall: What interested you in the Community Health Foundation idea?

Packer: I knew absolutely nothing about the Community Health Foundation. But I remember fairly clearly a day in the fall of 1963 when I was in the parking lot of the University Hospitals, the doctors' parking lot. I worked at University Hospitals, and Dr. Eugene Vayda, who graduated from Reserve a year behind me, worked there also. Dr. Vayda saw me either getting into or out of my car, and came over and asked me whether I had heard about the prepaid group practice that they were planning to start.

I had no idea, really, what prepaid group practice was, although I'll admit that I had been somewhat intrigued by the ads of the Southern California Permanente Medical Group which I had seen in the various journals: JAMA [Journal of the American Medical Association] and the New England Medical Journal. Also, one of my perhaps closest friends, well, certainly my closest friend—we had grown up together, we had gone to medical school together, we had even been in night school together much of the time--after two or three years in practice here (and he was a board certified internist) had told me he was joining the Southern California Permanente Medical Group.

At any rate, he told me he thought it was a wonderful opportunity. He was going to get something like eight hundred dollars a month, which in 1956 sounded like a pretty good income for a young doctor. He was going to get a car to boot, and all sorts of fringe benefits. I thought that sounded quite interesting. He also told me surgeons started for a thousand dollars, and my curiosity was piqued, but not enough to ever investigate.

Chall: What was his name?

Packer: Frank Shaft. He stayed in the medical group in southern California until he died, I think, seven years ago, of a coronary occlusion.

*See Avram Yedidia, Planning and Implementation of the Community Health Foundation of Cleveland, Ohio (Washington, D.C.: Public Health Service Publication No. 1664-30, April 1968. Deposited by Dr. Packer in The Bancroft Library.

Chall: Was he interested in it beyond the economics? Did he have some ideals about it?

Packer: I'm sure he did because, like me, he was developing a practice, but wasn't happy with many of the factors related to the fee-for-service solo practice of medicine. He wasn't happy with the need to be dependent on people's referrals. He wasn't happy with the need to be an entrepreneur; he wasn't happy with the uncertainty, with the fluctuations of income. And basically, he just wanted to be a doctor. He didn't want to deal with all these other kinds of problems. He was a good doctor, he was a bright guy, and interested in people.

Chall: Did you retain his friendship through the years?

Packer: Oh, yes. Yes, until the very end. When he died, his wife called me immediately and I flew out for the funeral. And, indeed, I was asked to offer a brief eulogy. Yes, indeed.

Chall: So you knew, through the years, how he felt about having made the move? Even before you were ready to?

Packer: Yes, we knew he was very happy being in California. He flew out on a miserable February day and arrived there on a beautiful day. He said, "If things are half decent, this is it, I'm not going back."

At any rate, Eugene Vayda approached me and asked me did I know about it? I didn't. He said, "There's a building going up on 117th and Euclid," which was within a half mile of the University Hospitals where we were talking; I didn't know that. I later drove by and saw this structure going up.

He told me they would be needing surgeons, and would I be interested? I told him it sounded extremely interesting. I was now nine years in practice. My practice now was beginning to build. I worked at two major hospitals: University and St. Vincent Charity, and I also had privileges I never used at Mt. Sinai. I never used them largely because the chief there was an absolute autocrat, Dr. Sam Freedlander. Dr. Sam Freedlander sort of limited entry to the surgical staff and the reason is obvious: he did 50 percent of all surgery down there. He didn't particularly care to support the competition.

As I say, my practice was now growing. I no longer was taking Academy calls—if you don't know what they are, that's when you call your Academy of Medicine and tell them you're available for emergency calls, which most of my colleagues and I did when we completed our training in order to get a practice started. I hadn't done that for years now. I rarely got called out at night

Packer: anymore. Maybe once every two or three weeks I would get called out in the middle of the night. I was making a living finally. And I enjoyed it. I had a pretty good reputation as a doctor, as a surgeon, in the medical community.

Sam Packer's Interest

Packer: But all the things that had appealed to Dr. Shaft appealed to me. The idea that I wouldn't have to run an office; I wouldn't have to go to meetings and impress people with my surgical brilliance, or be concerned with whether they would refer me. When some less-than-brilliant internist or pediatrician stupidly sent me a case that didn't need any attention, I wouldn't have to write a letter thanking him for "sending me this interesting case."

The income, although perhaps somewhat less than what I was generating, would be absolutely predictable; there would be fringe benefits that I wasn't buying for myself; there would even be a retirement program, which I hadn't begun to contemplate.

Finally, Dr. Vayda left me with the impression that the program would be University Hospitals based. I could almost see a surgical service of our own at University Hospitals where I was doing part-time teaching as well, and did for sixteen years. So all in all it seemed attractive. And in essence, every time I saw Dr. Vayda he was selling, recruiting. Not only that, but hardly a day passed when he didn't call me, or stop at my house, to tell me about the latest developments.

My wife liked the idea that I would have predictable free time and be more likely to take vacations, and if I got sick I would take time off--which did not prove to be true, because I hardly ever used sick leave later. I didn't take many vacations either. But be that as it may, it sounded attractive. Vayda kept talking about the department of surgery, and, "we're looking for a chief," and I finally asked him, "Well, Gene, who are you looking for as chief?" He said, "We want someone from University Hospitals to be the chief."

I knew there had been discussions with University Hospitals and I thought these had been discussions in depth. I assumed one of the young, senior surgeons there might be this intended chief. I asked, "Who is it? Who are you going to ask to be the chief? Is Charlie Hubay interested?" Charlie Hubay subsequently became the chief of general surgery at University and remained in that position for many years. He retired only recently. Gene said, "Oh, no, no, we want you to be the chief." Well, that puzzled me,

Packer: because then I would not only be in the department but I would be the chief, too, since we were, apparently, recruiting one surgeon.

Dr. Vayda then told me that I was to recruit another surgeon, and that Sam Freedlander, this autocrat at Mr. Sinai whom I mentioned before, and who was now nearly seventy and had retired as chief of surgery at Mr. Sinai, was interested. I found this extremely interesting, because Sam Freedlander made immense amounts of money. In the Jewish community he operated on half the Jewish people who required surgery. And many others. And as I say, he was known to be an autocrat, a tyrant, to his house staff and to the attending staff as well, and very caustic. Very brilliant, very competent, very articulate, but a tyrant through it all. I thought that was quite an interesting change of status, and it titillated me that I might be Sam Freedlander's chief.

Dr. Vayda told me another person was interested in joining us, and that was Charlie Cogbill. Charlie Cogbill had been my chief of surgery at the VA hospital and was my age. In other words, he had been a young chief at the VA. And I thought, my God, this is incredible. You know, if I have a department of three people, I will have Charlie Cogbill, and Sam Freedlander, and I'll be the big chief.

It excited me. I interviewed both of them, and we recognized the value of getting either, particularly Sam Freedlander, because he was a major name in Cleveland medicine. A very significant name. Meanwhile, I was up and down in my thinking. It wasn't clear to me what my duties would be. It seemed to me at times that I would be assuming a work load several times greater than my current work load, that I would be doing the work of an intern much of the time, and all that proved to be true, finally.

Chall: Excuse me, did you talk to other doctors around town about the development of this plan? Because it was group practice, and most doctors were not in favor of it. Did you have a feeling that you were going to be looked upon with disfavor in the medical community?

Packer: I was very concerned that I might be, and I talked about it casually to people at St. Vincent Charity Hospital, which, although a Catholic hospital, was ecumenical in its staff. Despite the ecumenicism of the staff, it had one consistent characteristic: it was extremely conservative. And I had many, many good friends there—Jewish, Protestant, Catholic, including many nuns who were very friendly. They all listened to me when I talked about this possibility, and the impression I got was that they thought that I was going off the deep end, and that maybe I was going through some kind of crisis. Obviously, they felt it wasn't really a totally rational thing to consider.

Packer: At the University Hospitals it was the same except more so—even more conservative. The comments there were similar, generally, particularly in surgery; so much so that I felt I had better talk to the chief, Dr. Holden, before making any move, because I might lose my privileges there if I joined this organization. I told Gene Vayda that I thought I needed to do that before I began to talk about a commitment. Gene said that he and Ernie Saward had been down to the school, had talked to people who had been very encouraging.

Chall: Had you met Ernie Saward yet?

Packer: Oh, yes.

Chall: So you did know that they were helping to set this up?

Packer: Yes, after Gene talked to me that September day in 1963, he started inviting me to meetings whenever Ernie Saward came to town, and I met Ernie. And I met Glenn Wilson, who was to be the executive director, although I never clearly, at that point, understood Glenn's role or his background. I met Avram Yedidia, and I met a man named Dick Weinerman, who was from Yale. I believe they were the only people involved at that point. So periodically there would be meetings and Gene would invite me to come to those meetings. A bit further down the line I found Bill Young, whom I met when I was teaching in the Group Clinic at the medical school. Bill came back from military service and was a fellow or senior resident of some kind.

Chall: He had also, then, been recruited by Vayda?

Packer: He was being recruited by Vayda because, after completing his training, Bill Young stayed on as the director of the student health service at University and had a part-time private practice. Bill was the All-American boy. He was a very socially conscious and socially interested person, and a real good doctor. So he was a classic target for Gene.

Chall: I see, but one would think all of his concerns socially would be not in the directon of this prepaid medical plan.

Packer: No, I don't mean that his concerns were—

Chall: Society.

Packer: —were in terms of society, high society. They were in terms of the great society. Social obligations, not social aspirations.

Chall: I see, very good. I just wanted to make sure. What about Sam Pollock?

Packer: I hardly knew Sam Pollock.

Chall: Because the thrust was through the union, was it not?

Packer: That all was very obscure to me; I had little interest in that. I vaguely knew that the unions had put up some seed money. I believe it was $50,000. Sam Pollock was an essential mover in that regard. I don't remember when I met Sam Pollock. I liked Sam, I recognized him for what he was, and that was a well to the left of center liberal who during the Depression, in the thirties, had graduated from Ohio State as a social worker, got involved in labor and was extremely liberal, extremely sincere, and extremely aggressive. He was on picket lines, and he got beat up picketing, but his philosophies didn't weaken.

I recognized Sam for what he was, appreciated the fact that he gave unlimited commitment to this program, and would make every effort to help it and support it.

Let me digress a moment to show you the kind of person Sam Pollock was. He came in one Monday after we had started up in '64, I don't remember how much later, with a cast on his leg. I saw him and found he had a small fracture, not a major problem, which he had sustained on Saturday when I was on call that weekend. I said, "Sam, how come they didn't call me from University Hospitals?" where he had gone for emergency care. And he said, "Well, I knew you were on. But I asked the resident, 'Is this really a bad fracture?' and he said no. I asked him, 'What do you need to do?' and he said, 'All I need to do is put a cast on.' And I asked him, 'Can you put the cast on, are you competent to put the cast on?', and he said, 'Of course.' So I told him, 'You go ahead and put the cast on, and I'll go see my doctor on Monday.'" Which gives you some idea of Sam Pollock. He was very concerned about the program, and very considerate of the people with whom he associated. But Sam Pollock was not one of the people I met regularly at that point.

Chall: So you were really just concerned with the medical side and its organization?

Packer: Yes, I had only a vague understanding—

Chall: Of what it was all about.

Packer: I knew Ernie Saward was from Kaiser out in Portland. I knew he was a medical director there. It was my understanding that he would take up residence in Cleveland and become the medical director in Cleveland when we started the new program, and that Gene would be an associate medical director and chief of medicine. I would be chief of surgery and Gene would be chief of medicine. Gene repeatedly had said, when I would be concerned about something and

Packer: cautious about joining, "Well, what are you worried about? I'll be chief of medicine, you'll be chief of surgery. We'll be running the show."

I asked, "Will there be an executive committee?" My understanding was that the four principal chiefs would be on the executive committee by virtue of their office: medicine, surgery, pediatrics, and OB. And he said, "Well, even so, we'll still be running the show." It didn't turn out quite that way.

Chall: How did it turn out? Well, first of all you had to say you would come on.

Packer: Yes, it was very difficult for me to make up my mind. They kept assuming that I would come on. I suspect they told Bill Young that I was coming on, which helped recruit him. I assume they told Freedlander I was coming on, although we didn't need help recruiting Freedlander.

It was very interesting that this plutocrat and autocrat had an enormous sense of social conscience underneath it all, and for many years had had an interest in prepaid group practice. He wanted to spend his last years in medicine getting something like this started. It wasn't difficult to recruit him. He was a great comfort and joy to me personally, particularly after I became medical director. He realized that I was independent, even as his chief of a small two or three man department. He gave me wise counsel, occasionally surgical, more often political. When I got fed up with the politics and was ready to toss it all, he calmed me down many, many times and reestablished my equilibrium.

Chall: He became a really good colleague, then?

Packer: Yes. Very, very valuable.

Sam Packer Joins the Group

Chall: So, you went in. Is that it? At the beginning?

Packer: Yes, I finally did. My wife and I agreed that it was reasonable to do it, and that if I didn't like it I could opt out and start over, although I probably would have lost many referral pathways.

I did talk to Dr. Holden. Dr. Holden, at that time, had <u>not</u> had any talks with Saward or Vayda or anyone. He knew almost nothing about the program and he told me that I could do better, in his opinion, than join this program. He suggested that I consider academic medicine again. I was very flattered because Holden had

Packer: turned out many department heads, at Yale, at Toronto, and Virginia, all major schools. I was flattered. I told him I thought I was too old. He said, "No, you're not." And he asked me how old I was. I told him, and he dropped the subject. I guess he agreed I was right and he was wrong. I was nearly forty-eight at this time, and that was a bit old for joining an academic faculty for purposes of academic progression. Had I been ten years younger I would have gone into academic medicine at that point.

I came back and told Vayda and he admitted that he hadn't really talked to Holden. He suggested I give it one more shot. I went back and talked to Holden again. I told him about Freedlander joining, and of course Freedlander, at one time, had been clinical professor of surgery at the old City Hospital where Holden had had part of his training. And so Holden said, "Well, if Freedlander is coming aboard, I expect it will be a reasonable thing to do." He assured me my privileges would not be jeopardized.

With that, and with a great deal of uncertainty, and after a visit to Sault St. Marie in Canada where Glenn Wilson and Ernie Saward suggested I visit a small prepaid group practice, I finally decided I would come along. I sent out letters to my practice in June of '64 telling them that in the future I would be associated with the Community Health Foundation but that I would be pleased to see them as far as possible on a fee-for-service basis. Although we understood, when we entered the group, that we wouldn't be able to keep that money, those of us who had been in practice were fairly anxious to keep seeing some of our fee-for-service patients. Just in case it didn't work out, we would still have something to turn back to. But the fees were turned over to the Community Health Foundation.

Indeed, I had a major industrial job with the B. F. Goodrich Chemical Company. I turned that money over to the Community Health Foundation, but I held on to the job, I think, for six months or perhaps longer, so that if this didn't work out, I would still have the job. But all this time, all the fees I earned operating on my own and other people's private patients, and from my industrial practice, I did not retain. They became a part of the revenues of the Community Health Foundation.

The Organization Takes Shape Amid Persistent Internal and Financial Stress

Chall: At the time did you have medical staff in each of the major professional areas: OB, ophthalmology, all the rest?

Packer: Yes; not all of the professional areas, all of the major professional areas—I believe you may have said that. Yes, we started with, I believe, five internists.

Chall: That's pretty good.

Packer: It was very good. Including Young, and Vayda, and Dan Bloomfield, Gene Ross, and Ron Fleming, who was a young fellow freshly out of training. In pediatrics we recruited a man, a little older than I, who had been in pediatric practice for many years at Mt. Sinai, and for whatever reason joined the group—Zoltan Klein. However, he was disenchanted after perhaps a year, and went back to Mt. Sinai. A couple of weeks after we started, Dr. James Phillips came along, having just completed his service in the navy. He had gone to Reserve and trained at University. Vayda and I and Young all knew him somewhat.

So we had two in pediatrics. In OB we had two people. We had Peggy St. Clair, who had trained at McDonald House at University and then worked for the coal miners in Kentucky, I believe, or West Virginia, for a while, and got fed up with that. In addition, there was Barry Fisher, who had just completed his OB training at Mt. Sinai.

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Packer: In surgery it was Freedlander and I. Freedlander worked only a limited schedule and took no calls, so that from July until sometime in mid-September I took all surgical calls. I had some assistance from a man on the full-time staff at University Hospitals, a Dr. Hastings K. Wright, who some years later went to Yale, and for many years has been the chief of general surgery at Yale. But I was responsible for all emergencies, everything, for about three months.

Then Dr. [Herbert] Jakob joined us. He had trained at Mt. Sinai and was one of Dr. Freedlander's favorite residents. Perhaps largely for that reason, Dr. Jakob joined us. Also he had had enough of three or four years of practice in Eureka, California, which perhaps you know. He found it an interesting and lovely place, but it wasn't the kind of practice that he wanted to do forever.

We had a part-time radiologist Keith Weigle, and a part-time ophthalmologist Jack Peretz. I think that may be it.

Chall: And the building that they were building was an outpatient clinic?

Packer: Yes, it was an office building.

Chall: An office with outpatient facilities?

Packer: A beautiful building, it won an architechtural award. Entirely an outpatient facility. Also, we had what I consider a rather considerable amount of ambulatory surgery, then probably far in advance of what was generally done. And we saw emergencies there. All day our telephone nurses directed almost all emergencies to come to our offices, even with fractures and lacerations and various other injuries. Only a major catastrophe was told to go directly to the closest hospital.

The building was kept open until nine at night, theoretically, with the internists and pediatricians taking calls there, having patients who called during the day come in during the evening. The surgeon was on call, and for anything surgical that came in, we got called.

Chall: What about other kinds of laboratory work, aside from radiology?

Packer: We had a laboratory. We had a reasonably decent laboratory set up.

Chall: So you had to recruit that kind of personnel as well—trained technicians?

Packer: Yes, but that wasn't—

Chall: You didn't have to do that?

Packer: —that was nothing for the physician. We didn't have much to do with it. That was the business of the nonphysician manager, Glenn Wilson, the executive director.

Within the Medical Group

Chall: And who was the chief of the medical staff there? Who took that over right away?

Packer: As I told you, Ernie Saward was the medical director for perhaps a month, and then to my surprise—Well, first of all I was surprised that Ernie didn't take up residence in Cleveland. He just came in every week for the weekly executive committee meetings, or group meeting, whichever it was. Sometimes he stayed two or three days and was in meetings all the time with Glenn Wilson and Gene Vayda.

After, I think, about a month, Gene sent out a memo saying that he was now the medical director, Ernie Saward would continue

Packer: as a member of the medical group, and that we now had an executive committee. I don't remember just when that was established, although I was shown as a member of the executive committee. So Gene was then in charge.

Chall: How did that sit with you?

Packer: Well, I suppose I should be entirely candid. Rather quickly a division, a schism actually, developed within the medical group. Initially it was a separation of the University Hospitals people, namely Vayda, Young, and I from the others who were basically Mt. Sinai people, mainly Phillips, Fisher, and Jakob, and whom else they would recruit on their behalf. They were very active people politically and recruited very effectively.

On the other hand, although Dr. Vayda was in the position of authority and active politically, neither Dr. Young nor I became involved politically. Perhaps rather naively, we believed that it was a great thing to do and everyone would have a great deal of commitment.

Chall: What was the schism--what was the basis for it? It couldn't have been just old school ties or that sort of thing?

Packer: No, it wasn't old school ties at all. It was a matter of supporting Ernie Saward, and Glenn Wilson, and Gene Vayda, finally, in dictating policies and even procedures, or expressing contrary opinion. And with the passage of time I found myself differing with Vayda and Saward much more frequently than I agreed with them. So that ultimately I became a member of the other camp, and, in the frankest terms, adversarial to Vayda, and Saward, and to Young, who tagged along with them.

Chall: What was the basis?

Packer: And the reason--the basis--was not difficult to understand. It was a lack of frankness, I felt, on the part of the people who were running the show. For example, all of a sudden Vayda became the medical director. Also, there was a lack of frankness at the very beginning when I committed myself. Just the weekend before we opened I came by and was told by Saward and Vayda that my office schedule was unacceptable, that I had to work all day Saturday like everyone else. I was furious, because I had made out a schedule quite some time before I committed myself. I had been told by Vayda it was perfectly fine. You know, I'm a surgeon; I was going to be out many nights, and I was going to see many emergencies, and to be in the office every minute of the time that I wasn't operating or dealing with emergencies, following the same schedule as internists and pediatricians--it was just ridiculous. It isn't the pattern of practice anywhere.

Packer: When Ernie Saward and Eugene presented this to me, after I had sent out letters to my patients telling them that I was discontinuing my own practice, after I had committed myself, after, presumably, I had burned all my bridges, I felt it represented something less than total frankness.

I expressed this opinion to Ernie and Eugene very clearly on the Saturday before we opened. Indeed, I told them that I resented it to such a degree that I would be impractical enough to offer my resignation at this very moment and start reconstituting my practice. They recognized that I was totally serious and promptly told me they would accept the schedule as it had been established previously. They said they understood the differences in my load and the load of internists, who would be on call one night out of five while I was on call every day, whose emergencies were far less frequent, who would not be getting called in to suture lacerations and deal with fractures.

There was lack of frankness there; there was a lack of frankness, in my opinion, when Gene suddenly became medical director. Originally the medical group was a proprietorship on the part of Ernie Saward. It was Saward & Associates. Then we were told at a meeting one day that Vayda had been made an associate, and now it was Saward, Vayda, & Associates. And then some months later we were told, again at a meeting—Gene said, "I want you to know that Bill Young has been made a member of the proprietors; it's now Saward, Vayda, Young, & Associates."

This was, obviously, after I had begun to have my differences with Vayda and Saward, at a meeting of the whole group of now perhaps fifteen doctors. I remember exploding at that point and demanding to know why these changes and decisions were being made without <u>any</u> prior discussion with the medical group. Gene gave some lame excuse, perhaps Ernie was there, too. I remember simply issuing an ultimatum. I told them, "I assume that perhaps next you will attempt to mollify me by making me an associate. I have no interest in being an associate, but I tell you that before there is another fait accompli, you damn well better discuss what you want to do <u>with</u> <u>us</u>. I give you fair warning that certainly I, and we, won't tolerate maneuvering decision making in a small group like this without full and free discussion."

So the lines were clearly established after that. It was Saward, Vayda, and Young versus Phillips, Packer, Jakob, and Fisher. That was a rift, a schism that existed right up until we became part of Kaiser. It was an unstable medical group. On any number of occasions I considered resigning. Indeed, during one meeting when I thought Gene Vayda got particularly cute about something that offended me, I offered my resignation effective--I

Packer: don't remember whether I said immediately or in thirty days, and walked out. Herb Jakob came running after me, and asked me to cool off, and please recognize it was important to the medical group that I stay and not abandon it at that point.

Chall: In a way, at that point, were you becoming a leader of that side?

Packer: Yes, without realizing it, I was becoming a leader.

Chall: Because you were outspoken?

Packer: Immodestly, this apparently has been my place in life. I speak my mind. I have not been one of the people to run for office, ever. I have been one of the people who spoke up. Even in medical school, I discovered, when the class had a gripe they wanted to take to the faculty, they asked me to do it. My wife was very amused by this when we were students, and she still reflects on that. At Charity Hospital, at Crile Hospital, I spoke out as a resident. And Crile, the VA hospital, it was I who went to the administrator and told him we just wouldn't tolerate the practice of admitting patients without problems simply for the purpose of keeping the census up.

I guess in my own family it's a little like that. My wife has told me on a number of occasions that, without realizing it, I dominate the family and that's one of the reasons all our kids want to be independent. We have a very closely knit family, but our kids all have a great need to feel independent. At any rate, yes, I guess I was taking on a role as leader.

This is the way it went, and at many of our meetings it was Ernie Saward, and Gene Vayda, and Bill Young--not really a very active participant, a very quiet participant--on one side, and on the other side of the fence Jim Phillips, Herb Jakob, Barry Fisher, and I. The other people were just sitting by. This went on for a number of years.

Chall: Well, let's see, you opened in--

Packer: Sixty-four. July 1, 1964.

Chall: And you didn't really merge with Kaiser until '69?

Packer: January of '69, four and a half years later.
Chall: This internal problem, then, was moving--

Packer: It was moving in a variety of directions. Those of us who were dissident, you might say, also had problems now accepting Glenn Wilson.

Chall: Why was that?

Packer: We felt that Glenn was impossible to negotiate with. We questioned his willingness, really, to come to terms in negotiations. Later, of course, we recognized that he was running the operation on a shoestring and really couldn't come to terms. We also had the impression that Glenn was less a manager and more a promoter, that his major skill was in the promotional area rather than the operational area.

Chall: What was his background; did you find out?

Packer: He came from Nationwide Insurance where he had been in the prepaid field.

Chall: Oh, he was a business man.

Packer: Yes. Glenn left after we became part of Kaiser. He had some major differences with Karl Steil, who was running the health plan end of our operation then. Glenn resigned, I guess, in '69.

Chall: Oh, right away?

Packer: Yes, within six months. It was speculated that he resigned rather than face an inevitable conflict with Karl, which would have been resolved to his detriment. Glenn said he was resigning to pursue a Ph.D., and we all snickered at that. We thought it was just a vehicle to explain his departure at this time. But, by God, he went to the University of North Carolina, got his Ph.D., and has been there ever since as professor of community medicine, I believe, and, I think, head of that department.

Chall: I think that's true.

Packer: Glenn told us what the facts were. So Glenn was adversary to us, and, of course, Ernie. And even Avram Yedidia, because Avram was conscious of the financial situation. You know Avram, I assume?

Chall: I know who he is, yes, and we have an interview with him in this project.*

Packer: Of course, we recognized that Avram knew about the financial instability of the program. We physicians, at least we dissident physicians, felt that we were being shortchanged financially in many areas. This was particularly true of Phillips and Fisher and

*Avram Yedidia, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985, Regional Oral History Office, The Bancroft Libary, Berkeley, 1987.

Packer: Jakob. The compensation was not the major issue for me, as it appeared to be for them. The major issue for me was a lack of communication, a lack of candor, and a lack of clarity about what we were doing, where we were going, and why.

Chall: In the meantime, what was the attitude of the doctors when you were working in University Hospitals and the other hospitals where you had staff privileges, because you didn't have your own hospital? How did they handle that?

Packer: There was absolutely no change in my personal relationships with even the most conservative of those doctors. And I got the same cooperation from them, and the same displays of friendship, that I had always gotten. Many, I believe, were hostile to the program. Except that if we referred a patient to them, they were quite willing to accept the patient and to accept the fee. Some of them, even, were quite willing to help us in periods of stress, despite the fact they may not have been strong supporters of the concept.

In orthopedics, we used a couple of the guys at University to see our orthopedic emergencies. In surgery, when I went on vacation, some of the very senior surgeons at University covered for me, and really never charged because they didn't want me to lose the fees. Frank Barry, who was the busiest surgeon around there for many years, and Jerry De Cosse, who is now the chief of surgery at New York Memorial, covered for me and operated on my patients in my absence. So my relationships there did not suffer at all.

Chall: Did others'?

Packer: Nor did Bill Young's nor Gene Vayda's, as far as I could tell, even though there was periodic debate in the dressing room or at lunch or somewhere, caustic debate, perhaps. But we were accepted, we didn't lose friends, we didn't make new enemies, we didn't lose privileges. The same was true with Charity Hospital.

With Hospital Privileges

Chall: I think Dr. Saward said that there was a nun in the Charity Hospital who was sympathetic to--*

Packer: Yes, that was Sister Ursula.

*Ernest Saward, M.D., History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985, Regional Oral History Office, The Bancroft Library, Berkeley, 1986.

Chall: And he said that she was sent to Appalachia. Was that because of—

Packer: Well, she went back to North Carolina, and that wasn't solely because of her sympathy for us. It was because she introduced many changes at Charity Hospital, and the very conservative staff rejected this. Sister Ursula was friendly, but we had a problem with hospital privileges. I don't know whether Ernie told you about that.

Chall: No.

Packer: Three of us worked at University, Drs. Vayda, Young, and I. Our pediatricians worked at University. And I believe Peggy St. Clair also worked at University. But all the rest of our doctors did not work there and could not work there because it was very difficult to get privileges at University. They were <u>impossible</u> in surgery, <u>extremely</u> difficult in medicine, and in pediatrics you got them if you were trained there. In OB it was very difficult—you got them if you trained there. Surgery, you didn't get them <u>even</u> if you trained there. There were two of us who got privileges in surgery in about fifteen years, despite the enormous number of people they trained there.

So we were at a loss for beds elsewhere. Dr. Jakob and Dr. Fisher trained at Sinai and could get beds there. But as we added doctors, they couldn't get privileges to University, they couldn't get privileges at Mt. Sinai; it was very difficult to get privileges anywhere if you joined our program.

I had a very good relationship with everybody at Charity including Sister Ursula. Our doctors started applying there with little response. One Sunday morning I got a call from a close friend, Dr. Bishop, chairman of the credentials committee, who said simply, "Sam, I'm concerned that we may be treating your guys unfairly. Would you and some of the big wheels from your operation meet with our executive committee?" I think it was a Sunday morning. So I got Saward and Vayda, and we went down there.

Chall: Was this the Charity hospital?

Packer: St. Vincent Charity Hospital, which was one of the four or five major hospitals in the city, major teaching hospitals. We had a meeting with the executive committee. Glenn Wilson was there, too. The hospital was reassured that they would be paid practically in advance, rather than have to wait for payment. They asked, "How would you deal with your patients medically?" I told them, "I'll deal with them the way I always have." The chairman of the executive committee, a thoracic surgeon, Bud Kay, said, "Well, we know how <u>you</u> will, but what about the other doctors?"

Packer: At any rate, on the basis of that discussion, the hospital elected to treat our applicants reasonably objectively. Our doctors got privileges there, particularly in internal medicine. Although it was difficult to get beds, they did get beds relatively reasonably. I might add, they earned those beds because our internists assumed, I believe, the major part of the teaching load, the house-staff teaching load at that hospital. That's how we got beds, and that clearly enabled us to stay afloat at that point. It was a fortunate coincidence of my very strong relationship with that hospital.

Chall: I guess that was necessary, that the major doctors be welcomed and know the area. That was true, I think, in Denver, too, when they started.

Packer: Yes, that's why they recruited Bill Reimers, and that's why I was recruited, I'm sure. Not only did they need my entree at University Hospitals in surgery, but they must have recognized that I might provide a mechanism for entree at other hospitals, like Charity.

Chall: Also, you had a reputation not only as a good doctor, but as a stable person in the community. You didn't just come in from outside.

Packer: Oh, I think I've always been considered a stable person. No matter how unstable I may have felt, I still have given the impression of stability.

With the Campaign to Build a Hospital in Independence

Chall: Apparently it was felt that you needed your own hospital at some point in time?

Packer: It was during this period, early in our existence, because the only privileges we had were limited to a few hospitals: University, where only a few of us were able to work, and the charges were high; Mt. Sinai, where only a few could work; Charity, where more worked but, again, where there was a difficulty getting beds. Internists would come to me and say, "Hey, why don't you admit this guy as an emergency? They won't give me any bed."

Furthermore, everything was fragmented, so all the advantages of a group practice were being lost. I worked at University and Charity, and not at Mt. Sinai. Dr. Jakob, Dr. Freedlander, and other surgeons worked at Mt. Sinai, but not University. And finally Dr. Jakob got privileges at Charity but worked there

infrequently. So it was not a real group practice. We started using bed at Poly Clinic Hospital, but weren't real happy about that because we did not consider that one of the better hospitals.

To make matters even worse, in my opinion the major hospitals in the middle 1960s were all on the east side. The major teaching hospitals were not on the west side. But those less than major teaching hospitals on the west side consistently refused to consider our people for privileges.

Chall: Where was your clinic?

Packer: On the east side. In 1966 we had started offices on the west side, on Snow Road. Despite that, we could not get privileges anywhere on the west side. The doctors who applied were getting very short shrift. And for those reasons, knowing we could get beds on the east side but only with difficulty and with great fragmentation of services, and that we simply could not get beds on the west side, we thought we had to build our own hospital. That accounts for the fiasco at Independence.

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Chall: Is it an independent city, or a neighborhood?

Packer: It's a small community south of the city.

Chall: It's a city, though? It has its own governing body?

Packer: Yes, it's a town, it has its own government. And it is conservative, somewhat ethnic, middle income, and the location seemed to be relatively central, although it was remote. Central, but remote from everything. I might add that we had talks with Charity Hospital for some time about the possibility of an arrangement with them, which really would have been ideal because it's a downtown hospital. It would have been very central to all our activities. But, again, I guess that fell apart because of the lack of funds to support such an effort.

But we acquired land in Independence. A number of surveys were done, not only to establish that it was an appropriate site, but to determine that we would get all necessary approval, and zoning approval. It became very quickly clear that all the surveys were greatly in error. Bill Young and I attended a public meeting held there in regard to our proposed entry, and, somewhat facetiously, on our way home Bill and I congratulated each other on getting out of there alive and unhurt. We had tried very hard to remain anonymous throughout the meeting.

The final survey, I believe, was a door-to-door canvas of the neighborhood, to determine their views on giving us necessary zoning. We were assured, then, that we would be favorably received. Shortly thereafter the formal vote was held, and by an overwhelming majority—something like five to one—the zoning proposal was defeated. This was on a referendum of the entire community.

Chall: Your Community Health Foundation management had taken it to a referendum because you were turned down initially, I understand, by the city council?

Packer: Yes. This was a public referendum. It was just an incredible defeat, which put a period to any consideration of using Independence.

Chall: Did you, as doctors, have anything to do with the way all of that went? I mean, as I understand it, either the planning commission, or the city council, or both, refused the zoning, and so you decided—the Community Health Foundation—on the basis of the surveys, that maybe the community was really for it, and so maybe you could win an election?

Packer: I don't really know why, because I remember being told that people were walking around with posters and repeatedly making statements to the effect "No Jews and niggers wanted," and that kind of warm reception, I felt, didn't make it likely. But the survey, the door-to-door survey, said that that was a minority expression of opinion. The survey was wrong.

There were the usual complaints about, "We don't want all the traffic, and the noise, and bustle, and commotion." But underneath it all was the knowledge that the employees, the work force, would be largely black. Independence, at that time, perhaps even today, was totally, totally white.

Chall: Was there also concern about the patients who might come? There would be other races among them, too.

Packer: Yes, I believe that the assumption was that the patients, also, would be largely black.

Chall: So you were bringing a new group into the community.

Packer: So we were bringing many undesirables into the community, right.

Chall: That must have been a serious blow to the organization.

Packer: Well, I never knew how serious. We never knew how serious, we dissidents. I'm sure Gene did, and I expect Bill Young did. I know Ernie and Avram did; and I know Glenn Wilson did. I suspect that was one of the reasons that when we tried to arrive at a capitation agreement, we could never come up with one. (I assume you're familiar with that term, capitation.) After a number of years of being on cost reimbursement, Glenn always didn't quite come to a conclusion. I assume Glenn was just concerned about his ability to fund something on a capitation basis where there was a risk that he would be unable to come up with the funds.

Chall: So you never knew the financial problems?

Packer: We never knew, no. I knew there were financial problems. I knew they were considerable, but I really didn't know how deep they were until, I guess, '68, when there began to be talk about needing to make major loans and there began to be discussions by largely Glenn, I guess, about the difficulty we were encountering in being accepted for loans. And finally the suggestion that we might turn to Kaiser for a loan because of common interests.

I knew that Gene and Bill Young went out there. I believe Herb Jakob was out there too. I was never a party to these visits. I not only was on the other side, but, as I told you earlier, I was one of the people who was less concerned with financial things than with the matters of practice philosophy and communication and trust and candor. So not being one of the financially minded dissidents, I guess I simply never even knew about some of the trips that were planned and were made out to the west coast with Kaiser. Finally I knew that trips were made out there, and that we were asking for a loan.

I think you asked somewhere [outline] what kinds of considerations for the future of the group went into the debates about the merger.

Chall: Yes. Well, you had certainly been in on some of those when that was being considered—on the medical side.

III THE MERGER WITH THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Deliberations Preceding the Merger

Packer: You asked about Glenn at the time of the merger.

Chall: I'm really interested in what was happening at the time of the merger. You would have been concerned on the medical side, not with management.

Packer: You see, we recognized about this time that if we didn't merge the whole program might go to pot. It simply might fail. There was a great deal of mutual concern being expressed. We met at someone's house. Glenn was there, most or many of the doctors were there, and, I guess, Glenn discussed the possibility of merger with Kaiser. We supported that, and in essence said, "Well, the alternative is that the program is going to fail. Therefore we need to give serious thought to a merger." Glenn spoke up and said, "I don't want there to be any conclusions reached to the effect that we are going to merge, or are considering merging, with Kaiser to avoid collapse of the program. That's not true; we're merging with Kaiser because it's to our advantage to do that."

We left the meeting feeling—I believe I spoke up and said, "Certainly we'll not object to putting it the way you would put it, rather than in terms of merger versus failure." A number of us recognized that Glenn's reputation and ego needed some support at this point. It was an extremely difficult period, with great risk to many careers, including physicians. I had now been out of my own practice for over four years, and to restart a practice after four years is not easy. All the people who had sent me patients previously now had well-established new referral patterns. All my old patients who had relied on me heavily gradually had found it was getting more and more difficult to see me, and had gone elsewhere.

For Glenn Wilson to put on his CV that he had managed a program that had gradually failed would not have helped his career.

Ernie's career would not have suffered, but Ernie's ego would have been hurt; the same, perhaps, for Avram and Dick Weinerman. If not their egos, at least their ambition to promote prepaid group practice would have suffered a blow.

Chall: And were there some of your physicians on staff who had never had any fee-for-service practice--had gone directly from medical school to you?

Packer: Most. There were only Vayda, Young, Herb Jakob, Sam Freedlander, and I who had. Certainly most had had no prior fee-for-service practice. Some who joined us from fee-for-service practice came from another setting.

Chall: Other than the fact that it would have been difficult to establish your own profession again, were you committed by then to group practice as a form of medical practice?

Packer: I don't know whether I was fully committed at that point. It had been a very difficult way of practicing medicine. It had been much more difficult to practice that way than it had been in my last few years of my own practice. I was taking a lot more calls; I was being called out at night a great deal more than I had been; I was doing things that I hadn't done since I had been an intern or junior resident--sewing up lacerations, and treating a variety of relatively minor fractures and not so minor fractures. I was having to do urology that I hadn't had to do, and having to intrude on a variety of specialties where I had never had to intrude before. It was not an easy way to practice.

And on top of that there were the political differences which suggested that a group practice isn't always harmonious and idyllic. I wasn't sure that at that point I was committed, and I'm not sure that, had the program failed at that time, I would have looked for another group practice.

Chall: That's interesting. So it was determined then that they would check with the Kaiser people?

Packer: Yes. And this is when we met Cece [Cecil] Cutting and Karl Steil and Scott Fleming.

Chall: They came then?

Packer: Well, they had come, I guess, several times, but most of us met then. Certainly, I met them for the first time at a group meeting. I think, perhaps, it was an executive committee meeting. And that would have been very late in 1968.

Chall: At this point was the management team more forthcoming with the medical team about the whole situation?

Packer: Yes, I think so. I think we all understood, then, that instead of a loan we were now negotiating for a merger, that there was interest on the part of Kaiser in extending the concept to somewhere other than the west coast, that if there was a merger they would support our financial needs until we were self-surficient financially, and that we could rely upon their expertise as well to be of assistance to us in operational ways.

It was an exciting thought for a program which had started very small, very insecurely, and which had grown larger but more insecure. The idea of becoming a part of what we saw as an enormous program, and an enormously successful program, and one that was enormously wealthy, too, from our point of vantage--we felt all of that was extremely exciting and would change our outlook for the future very dramatically.

I didn't know a great deal about the meetings going on at that point with the people from Kaiser. That didn't really bother me because I knew a lot of people were meeting with them and I knew they included people from either side of the line in the medical group. It was of no concern to me at all. So I was perfectly satisfied that I had a good enough idea of what was going on, although I didn't know all the details. But as I say, I think Jakob and Phillips or Fisher, from the other side of the line, were out in California along with Vayda and Young at one time or another.

Chall: Did they ever talk to you about it, or were you just sort of going on your own way?

Packer: I don't remember a great deal about it. I'm sure there were casual conversations, but I wasn't particularly concerned at that point. I thought that there would be a vast improvement, probably.

Chall: Which is what you were hoping for?

Packer: Yes. I had no political aspirations of any kind. I was trained to be a surgeon, and I was a surgeon. I just wanted to practice in reasonable comfort and with reasonable assurance of what was going on.

I had met these people from Kaiser, as I say, at a group meeting or an executive committee meeting, late in '68. I know Cutting was there and Cliff Keene, Steil, and Scott Fleming; I don't know whether anyone else was there. I had had no idea who they were. I finally understood that Cutting was a doctor, but

the president of the health plan and the regional manager of northern California, I didn't understand. I had no idea who Karl Steil was, or what he represented, or what Scott Fleming was, or who Cliff Keene was. I had heard of Edgar Kaiser and I vaguely knew that somehow he was involved. And I didn't much care.

Chall: What a shock it must have been to your system when you had to care! [laughter]

Packer: Oh, it was a great shock. And an even greater surprise. At this meeting I believe we dissidents went in there—at least I went in there—feeling that it looked good. Finally we asked, "What does this mean to the medical group?" and I believe we were told it meant relative security and assurance. I don't know whether it was I or someone else who then asked about our ability to function as a medical group relatively independently.

I guess Ernie was there too, and I guess it was Cece Cutting who spoke up and said, "Well, of course you would be able to function independently, but if you want to do things significantly differently, why, we may have to intervene at that point." I asked how they would do that and was told that Cutting would join the executive committee and Saward would stay on. They would stay as long as was deemed necessary.

I guess my old adversarial stripes were repainted by this, because I asked—and this I remember clearly—I asked, "What if we refuse to add the two of you to the executive committee?" Cece very quietly told us that in the event that we refused they would just have to reorganize the medical group. I thanked him for the candid answer. I really had no problems with the two of them being on the executive committee, particularly since Ernie had been on from the beginning.

Later I got to know Cece a bit, not well, but we talked for a half-hour or an hour. He sounded like a surgeon and was very low key. We're both tall, and we both got a little stooped over from bending over an operating table. I thought he seemed like the kind of guy, like many I knew, with whom I had much in common. I didn't have any concerns about Cece being on the committee. My intuition proved correct.

Chall: At what point, then, did you know that Kaiser had taken over or that the merger had occurred and that they were now going to reorganize, or organize the medical group in the Kaiser mode and method?

Packer: Well, they never reorganized the medical group in any way, because we were a prototypical group in the Kaiser Permanente pattern.

Chall: Yes, that's true.

Packer: Kaiser Permanente organization was there right at the beginning, due to Ernie Saward's initial involvement.

Chall: That's right.

Packer: So the medical group was organized largely on the pattern of Kaiser. The only change, then, was that Cece Cutting was now added to the medical group, to the executive committee, and we understood that if we tried to go off the deep end, Cece and Ernie would intervene, and that could lead to serious organizational changes.

Chall: Vayda had been the medical director up until then, is that right?

Packer: Remember, Ernie Saward for about the first month and then Vayda. At the time of the merger Vayda was the medical director, and as far as we were concerned—as far as I was concerned—would be, essentially, forever. Gene's about nine or ten years younger than I am.

Chall: I see. What happened?

Packer: Much to our amazement, Gene came into a meeting and told us he was planning to take a year off to get a MPH degree [Master of Public Health] at Yale—or it was a fellowship; I don't remember the details. We were all extremely surprised, because we were just becoming a part of Kaiser, and we knew it would be a very sensitive period.

Gene said he would like to take a leave for one year, and the committee said, "We need to think about that for some time. A year is a long time. We need to give it some thought. Particularly during this period of change and lability." Gene offered the committee three options when it next met. I read this a couple of hours ago in a bound copy of our executive committee minutes, and I remember them. One would be to take a leave as medical director, two would be simply to take a leave and return as a member of the medical group, and three would be to resign.

Of course, as you gather by now, Gene would not have won a popular election for anything in the medical group at this point. The executive committee concluded that he should take a year's leave of absence and return to the medical group, but resign as medical director. It was felt we couldn't have an interim medical director for a year at this point. Gene accepted the option of taking a leave for one year and then coming back. That was, I think, in early March of '69.

Sam Packer Elected Medical Director

Packer: It was somewhere along in there, because I went on a very brief spring vacation trip with my whole family. We put all five kids in a car—a two door, never a four door, because I didn't want them messing around in the back and opening doors.

Chall: Good heavens!

Packer: And it was interesting, I tell you, but it was always family vacations. As soon as they would hear my wife and me planning a vacation--if we ever thought of going away by ourselves—then they would chime in and say, "Well, I don't want to go there, let's go there." They were always family vacations.

At any rate, I got back home on a Friday night, about nine o'clock, really tired and probably somewhat irritated after driving with the kids all day. I had barely walked in when the phone rang; it was Barry Fisher, and he said, "Sam, we're having a meeting to choose a new medical director. We've been calling you over and over again. Where have you been?"

I told him, "I've been on vacation. I just got home this minute." He said, "Well come on down, we're going to have an election." I told him, "You go ahead and have an election. I'm just too doggone tired to come to a meeting at this point. You go ahead and have an election; you don't need me to have an election." He asked me to hold on and he came back to the phone a few minutes later, and said, "If we meet tomorrow afternoon, Saturday afternoon, will you come?" Why, I couldn't see any way out of that, so I agreed, yes.

And we met. I guess there were Vayda, Young, Phillips, Jakob, Fisher—

Chall: St. Clair?

Packer: I don't know whether she was there or not.

Chall: She wasn't on that board yet?

Packer: Oh, it wasn't so much a board. I'm not sure Fisher was on the board yet.

Chall: No, he wasn't.

Packer: Just the activists and the board members met. The whole board was there, I guess, or executive committee. And we started talking. I discovered, shortly thereafter, that we were going to get nowhere, because everyone was nominating himself and explaining why he thought

Packer: he ought to be the medical director. Not knowing what else to do, I said, "I assume the appropriate thing is for me to say that I should be the medical director, too." Although I hadn't the remotest idea--. As I said the night before, "You go ahead and have your election, I don't care what you do, I'm not coming to any meeting!"

Finally, I guess, it was just generally recognized that a compromise had to be achieved, and so they asked me, would I accept the job? I was horrified! I was absolutely horrified because I didn't know anything. Gene talked about FTE's [full-time equivalents], and converting dollars to FTE's. I didn't know what he was talking about; I had no idea. As I say, I had gone into prepaid group practice largely not to be the small time entrepreneur that I had to be in my own practice.

There was no way out. I walked out of there just absolutely overwhelmed and amazed and scared.

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Chall: So what, then, did you have to consider for yourself, and with whom did you work it out? How did you start?

Packer: The most obvious thing immediately was that I would have to try to work very closely with Glenn Wilson, a person with whom I had consistently been in an adversarial relationship, and who apparently had respected me as a physician but hadn't cared for my opinions otherwise, particularly, and vice versa. I think we both recognized that the die was cast as far as our relationship was now concerned, and that we had to make an honest effort to work together. In my opinion we did. I know I did, and as far as I could tell he did too.

We went from an adversarial relationship to a relationship in which I felt rather insecure about what I was doing, and, I believe, in which he felt that it would be necessary for him to accommodate himself to the facts of life and recognize that I was medical director. And he did. He was most cooperative, and even accommodating, and appeared to want to please in every reasonable way. I quite honestly admitted my ignorance and how heavily I relied upon him for understanding the business aspects of the program.

IV THE TERM AS MEDICAL DIRECTOR OF THE OHIO PERMANENTE MEDICAL GROUP, 1969-1983

Setting the Terms for the Officers of the Medical Group

Packer: As far as the medical group was concerned, I told them at the very beginning, when they nominated me to be the medical director at that unusual pair of meetings, that I would take the job only if they all wanted me. The medical group was small; we had maybe fifteen, eighteen partners at that point. I said, "If everyone wants me, okay. If anybody doesn't want me, get another boy. I don't want to be involved in politics anymore. I've already had a bellyfull in the last four and a half years." So in essence I said, "If there is a single dissenting vote—"

Chall: Just one!

Packer: Well, we were small, very small.

Chall: Yes, that's right. You didn't want a schism.

Packer: And this was a job I didn't particularly want. If I was going to do it, I felt they had to want me. "I've got to be drafted in the real sense of the word or it's not worth taking." I also felt, on the basis of what I knew about the other regions and what I knew about Ernie Saward's background, that the medical director had to have security. Particularly in my case, I could not see myself engaging in a political campaign periodically to maintain my position or currying the votes by not doing what I felt I needed to do. So I also suggested that I had to have tenure. I had to have broad acceptance to begin with by the medical group, and I had to have tenure.

Chall: Meaning what?

Packer: Meaning that I would not have to stand for periodic reelection. That I would be the medical director, essentially, as I understood the medical directors were in the Permanente medical groups, for life or the equivalent.

Packer: First of all the vote was held, and there were no dissenting votes, so that was fine. Next, they agreed that I would be medical director to age sixty-five, which seemed pretty reasonable. This, as I understood it, was the way it worked in the other regions for Cece Cutting, for Ray Kay, and for Ernie Saward.

Chall: It did, only I didn't know that they didn't have to stand for election every number of years.

Packer: I'm quite sure they didn't, and I'm absolutely positive I didn't.

Chall: That is very interesting.

Packer: At any rate, this was obviously also acceptable, except that the committee that was appointed to determine things like tenure recognized there had to be a mechanism to remove the medical director from office. The mechanism they established made it possible for a simple majority to remove the medical director. I took exception to that, feeling again that I've got to be concerned with very basic politics. If one vote more than one-half of all possible votes in a small program could remove the medical director, he would always be in a political game. They agreed with that, and they changed it so that the medical director could be removed only by majority vote of the executive committee and by three-quarters vote of all the partners. I felt if I couldn't handle that I didn't deserve to try it. At any rate, on that basis I became medical director.

Ernie Saward, after I became medical director, called me and said that he would not intrude into my business now. He would not attend the executive committee meetings. However, he would be available, and if I ever wanted him to attend the meeting, or if I every wanted his advice or consultation in any way, he would be available. And he was, and that's exactly the way it worked. I got to know Ernie much better; we became good friends, and he gave me valuable advice on more than one occasion. Indeed, I called him once in Spain for advice in regard to an appointment being made by the health plan.

Cece Cutting also was on the executive committee. Cece came to about two meetings in six months or a year, and finally called me one day and said, "I really don't see any point in my coming to these meetings. I think I'm just going to resign from the executive committee. You don't need me." And he did resign. I don't remember precisely when.

Ernie Saward did not resign for some length of time. I believe Karl Steil, somewhere in the early seventies, felt that Ernie was not a participant in medical group activities and

Packer: therefore asked him whether he felt his continuing participation as a member of the executive committee made any sense. Ernie agreed to resign.

At the beginning, to provide a kind of stability, I felt the medical group--one that had been racked with differences, and dissension, and had gone through a period of great lability--I felt not only the medical director, but also the executive committee members needed some tenure. Again, I knew they had extended periods of tenure in northern California and Oregon.

Chall: Northern California? Not southern?

Packer: Northern California particularly, and Oregon, where they had three life-time members, I believe.

Chall: I noticed you had a very stable board. I wondered how that came about.

Packer: Well, that's how it came about. We arrived at long-term tenure for the executive committee. I believe that there were five of us locally, one being the medical director with tenure, and then the tenure for the others was nine, eight, seven, and six years. And, of course, Saward and Cutting. We agreed in our revised articles of partnership--our partnership agreement--by amendment that when Cutting and Saward left we would replace them with short-term members whose terms would be two and three years. Probably in '70 or '71, those people were added and we became a seven-man executive committee.

Then we agreed that at a certain point in our growth, two discretionary members would be added, and we became, somewhere along the line, a nine-man committee. And so we had finally, again in my view, a way of ensuring stability by having five long-term members and four short-term members. A nine-person executive committee because Peggy St. Clair came along there somewhere.

Chall: Yes, she came in early. The first time I saw her name is 1970.* She's been there a long time.

Packer: She then probably replaced Cutting or Saward.

Chall: No. She came in before that, because Cutting and Saward's names are still on the list. And their last terms were 1972. She was on before that.

*The annual reports of the Kaiser Permanente Medical Care Program list the officers of the medical groups in each region.

Packer: It's difricult for me to remember. I assume that Cutting said he simply would not attend meetings, and finally resigned, after which Saward also resigned.

Chall: Then you brought on some new people.

Packer: We probably added the two discretionary members first, and then added the two to replace Saward and Cutting afterwards, in view of their non-attendance.

Chall: Just so you could have a decent forum.

Packer: We ended with nine members.

Chall: Nine including you. Because I only count eight other names.

Packer: Nine including me, that's correct. Initially we were a seven-man committee including Saward and Cutting. Because of the usual absence of Saward and Cutting, we went to a nine-person committee permitting attendance of seven. After Saward and Cutting retired from the committee we were obligated to replace them, and that led to the nine. We have been a nine-person committee ever since.

Chall: Five long-term members and four short-term. And that's not too short a term, is it?

Packer: Two or three years. Two for two years, two for three.

Chall: And can they be reelected? I guess they can because their names just carry on.

Packer: Yes. There was no bar to reelection--ad infinitum.

Chall: So that gave you stability in your committee.

Packer: In my view it gave us stability, and I continue to think that it did. It meant that I would not be part of the political process, and it meant that someone elected for six to nine years also did not have to concern himself about the reelection process for most of those years. Meanwhile there was an opportunity for new people to come forward periodically because of the short-termers.

Chall: Which you do need, really, to do.

Packer: Yes, I thought so.

Chall: Some of these people were on for many years, like Peggy St. Clair.

Packer: She was reelected periodically, but at the beginning Young, Phillips, Jakob, and I think Dan Bloomfield may have been the long-termers. I'm not sure.

Chall: There's a Ronald Fleming I see for many years.

Packer: Ron Fleming. I don't remember when he came aboard. I would assume he was a short-termer.

Chall: Seventy-one. Stayed on for a long time. Was still on in '82.

Packer: Yes, he had been reelected to a long term. He was on until 1985, when his term expired and he was not reelected. The incumbency appeared to be important for many years, which, I believe, reflected on the stability of the medical group. If one was elected to the executive committee, reelection was almost automatic. This is quite different from the political situation in recent years.

Chall: Has it changed?

Packer: Yes, we're a corporation now.

Chall: I see. And that requires different kinds of elections?

Packer: Oh, yes. Entirely different, and the election process is different. There's a statutory limitation to term; the statutory term is three years. Election is not a pairing off of individuals or at least a squaring off of a number of individuals against each other for a specific office. Now there is a slate of candidates for office, and the three with the highest number of votes every year are elected, so that there is a total complement of nine board members, three of whom are elected annually. The three who get the highest number of votes are elected.

Cumulative voting is permissible, which means the opportunities for politicking are greatly increased. I'm absolutely delighted that I am not a part of the corporate political process. I would have found it very distasteful.

My view as medical director was that I should not participate in the political process. I had no need to participate on my own behalf, having tenure to age sixty-five. I flatly refused to participate on the behalf of candidates for election to the executive committee, it being my opinion that there were too many opportunities for disaster for me there. If I supported someone

Packer: and the person was not elected, it weakened my position. Similarly, if I opposed someone who was elected it did very little for me. As it was, people entered the executive committee feeling that at least publicly and openly I had been neutral, so there was a much better opportunity for the two of us to establish a good relationship. And it really worked that way.

New members came aboard periodically who were potential problems, but after the passage of a relatively small period of time they became effective members of the executive committee, with whom I had no more or less trouble than anyone else. Mine's a pragmatic and personalized philosophy of managing, and it focuses around the idea of minimizing political activity, and assuring stability based on that fact.

Getting Started: Combining Administration and Surgery

Chall: Did you take on administration full time or were you able to carry on some medical work?

Packer: No, I certainly did not take it on full time. Initially, the only difference being medical director made was that I took three mornings a week for administration. Or it probably was two mornings a week and one afternoon, because I operated three mornings a week.

I was an administrator three sessions: two mornings and one afternoon a week, and the other four afternoons I saw patients. I took my call—night call and weekend call—as I always had. I continued to do this for the next four years.

During that period of four years I gradually had to increase the amount of administrative time, and I finally took either four or five sessions for administration—I'm not sure which—but I continued to operate up to three mornings a week, and to see patients in large numbers and to take call.

In March of 1973, while en route to Australia—actually, while flying over the United States—I developed severe abdominal pain which, for some reason, people thought might represent a myocardial infarction. It was on a plane full of doctors who gathered around me. One doctor stuck a pill in my hand and told me to take it. I could hear others muttering, "He's having an MI." I asked this doctor, "What is it?" and he said, "It's Benadryl." I told him, "Well, why are you giving me Benadryl if you think I'm having an MI? That's an antihistaminic." He said, "Yes, I know, but that's all I've got," which amused me, even under the circumstances.

Packer: I got off the plane in LA, where we had a scheduled stop, and was immediately rushed to the Kaiser hospital on Sunset. They put me in coronary care for five days, although I did not have a coronary. However, it shook up my colleagues in Cleveland sufficiently so that they took me off night call at that point.

And then over the ensuing several years, as we got busier and busier, I gradually cut back on my clinical work until during the last five years or so as medical director I was scheduled for one-half day a week in the operating room and one-half day a week seeing patients. But I flatly refused to stop doing clinical medicine, which was a major point of difference between Dr. Reimers and me.

We discussed this very early, not long after we became medical directors, and Bill said that he felt that to do the job as administrator he had to do it full time. I felt that I was not a full-time administrator. I was a doctor who was also doing administration, but my primary job description was that of doctor. I was an administrator only secondarily, and not on a professional basis. I kept very active in medicine and finally somewhat active in medicine up to January of this year, when my colleagues simply decided that there would be an automatic age cut-off for clinical medicine, and I had reached it.

I must admit that I expressed considerable resentment, and challenged them to deny the quality of the medicine I was providing. Again, this is a major philosophical view. I'm a doctor, and the only reason I had the respect of the medical group as an administrator was because they recognized me as a doctor who was a colleague, who was doing the best job he could to be the administrator of their business.

Chall: I think Dr. Cutting stayed in medical practice as well for many, many years.

Packer: Yes. I know Dr. Bruce Sams did; he still does. Ray Kay did, I believe. And I think Ernie Saward did too.

Chall: Yes, he did. He made a point of it. How about the administrative side? I think that Dr. Reimers was sent off to--*

Packer: Harvard.

Chall: Yes. To study administration.

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*W. L. Reimers, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1986, Regional Oral History Office, The Bancroft Library, Berkeley, 1987.

Packer: The Advanced Management Program.

Chall: Right. Did you go to one of those?

Packer: For many years I was very proud of the fact that I was the only medical director who had flatly and consistently refused to go to the AMP.

Chall: Is that right? [laughter]

Packer: Yes. I was offered the opportunity--

Chall: I'm sure you were.

Packer: —at the same time as Bill Reimers. Cliff Keene just urged me to go. I flatly refused. Well, there was a selfish and a personal reason. I felt it would be difficult for me to be away from my family for six weeks at a time, even three months. The kids were all home. It would have been difficult.

The other was that I honestly believed in the joint management philosophy. I didn't believe that spending three months at Harvard could refine my management abilities so greatly that I would become a better manager than I already was. I felt that instead I needed to rely heavily on my partner in joint management, the regional manager, just as he needed to rely heavily on me for matters related to the delivery of medical care. I've always honestly believed that.

I also felt that although I didn't know some of the technical details of management, I could go to the regional manager, health plan manager, or controller for support, and that understanding most things was a matter of basic logic rather than of special education.

I believe that to this day, based on my discussions with Bill Reimers, Hart Baker, and the three doctors in this medical group whom I sent to the Harvard AMP program later, even though I did not go. From my discussions with them I recognized that it was interesting, it was gratifying to the ego, and one made a lot of important and interesting friends. Nonetheless, those people didn't come back knowing a heck of a lot more, nor were they particularly better qualified to manage than they were before they went. And that's my somewhat nihilistic view on AMP.

Chall: So you did not go.

Packer: I believe I described at a Kaiser Permanente Regional Management Committee my view on my relationship with the regional manager--and my dependence on him for some things—as it being a joint operation in which he knows the words and I know the music.

Developing the Team

Chall: Well, what about those regional managers? There had been several of them during your tenure, Karl Steil being the first.

Packer: Actually Glenn Wilson was the first.

Chall: Oh, yes, Glenn Wilson was the first, and then you described how soon after he left.

Packer: Yes, within six to eight months Glenn left.

Chall: So Steil, really, then took over.

Packer: Steil took over.

Chall: In an interim position, I think.

Packer: Well, in name, at least, and in fact. But the man who was doing the day-to-day management in Cleveland was Felix Day.

Chall: Yes. What was he like as manager?

Packer: Felix Day was not considered by most to be the most desirable person on the job. He had some personality characteristics that offended some. He had, obviously, a background primarily in facilities. He wasn't universally well received. I made a strong effort to work closely with Felix. Karl Steil knew the problem, and he knew that it wasn't getting any better. Therefore he retained the position of nominal regional manager.

You must understand at this point, when we merged into the Kaiser Permanente program, that northern California assumed the role of a big brother region to us, and southern California did the same for Denver.

Chall: I know that.

Packer: Karl, therefore, had more than a casual interest in the proceedings here in Cleveland. Felix Day made a number of important contributions, but he never established a good relationship with a number of people. I thought he and I got along reasonably well, and I like to think he felt the same. But we had differences, nonetheless, periodically.

Chall: And there were differences with others in the team?

Packer: There were differences within his team and there were differences between his team and the medical group.

Chall: He wasn't here more than about a year.

Packer: Roughly. Ronald Wyatt came in, I think, September of '70.

Chall: That's right.

Packer: Ron, of course, had a strong facilities background too, but on the other hand Ron was a person who fit into a group situation considerably better than Felix Day.

Chall: He was here about four years.

Packer: Yes, he was here approximately four years.

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Chall: With whom were you in contact most of that time?

Packer: At the top level, you see, were the medical director and regional manager. I believe that was pretty generally the understanding. However, I felt that, directly or through the regional manager, I needed to work with the regional facilities person, the health plan manager, and the controller. I know Ron Wyatt felt that way also. Periodically he would call meetings of all those people, which I would attend. There would be a discussion of program problems, including the medical group as well as others. That went on for some time, and I, of course, would then report on the proceedings of those meetings at the executive committee meetings.

I finally decided that wasn't a good arrangement. For one thing, there was one of me and a half a dozen of them. Although they assured me that was a reasonable balance, I was flattered but didn't really agree. In addition, I felt it wasn't wise to be a conduit to the medical group for the information derived at that meeting. To avoid the possible political charges of playing footsie with the health plan—which is a very common charge in this kind of program—I felt that there should be other physicians present at these meetings.

So I suggested the development of what was first ORPAC, the Ohio Region Policy Advisory Committee, and later, I think under John Capener, became KPRMC, the Kaiser Permanente Regional Management Committee. This committee would meet once every month or six weeks to two months.

Chall: Who made up that?

Packer: On the health plan side there was the regional manager, his health plan manager, the facilities manager, the controller, and any other selected persons who might be present by invitation. On my side

Packer: there was the medical director and the two physicians in chief, and, finally, when we extended more status to Severance, the physician in charge from Severance, who, incidentally, was Dr. Young. Regularly, the medical group was represented by Dr. Jakob (the physicican in chief on the east side), Dr. Phillips (the physician in chief on the west side), Dr. Young (the physician in charge at Severance—a lesser appointment), and the medical director. And then physicians by invitation.

Chall: So that took it out of the realm of management as such.

Packer: Took it out of the realm of management by a committee on the part of the health plan and one individual on the part of the medical group. It gave me some company and it removed any possible onus in regard to my operating totally as a soloist.

Chall: Sort of like a minor Kaiser Permanente Committee.

Packer: Yes, exactly. Maybe subconsciously that was a factor, I don't know. I never thought of it in those terms until you said it.

Chall: In a committee like this you could discuss all kinds of things; it wasn't just managing and budgeting.

Packer: No, no. All reasonable considerations: strategy, planning, problems. There was some confusion at the beginning because, in my opinion, Mr. Wyatt frequently looked for solutions at these meetings, for conclusions and directions. I took exception to that. I said, "I can't be a part of a program being managed by a committee. My position--and as you may remember, it wasn't one that I accepted cheerfully--but my position is to run the medical group, to take care of its business, and your position as regional manager is to run the health plan, and together we run the program." It was my view that KPRMC was an advisory committee, and that it made its recommendations to the regional manager and to the medical director. I felt quite strongly about that.

Chall: Then your team, the small group, would go to work on decisions?

Packer: Yes, it was then our responsibility--the regional manager and the medical director--to make decisions in any way we felt was appropriate, then to delegate responsibility.

Building the Medical Centers: Expanding the Program

Chall: Now, it wasn't as complicated until you decided to build a hospital, at which time you had need for facilities management.

Packer: Yes, that was 1970, it was very early in my tenure. We bought--Felix Day found Snow View Nursing Home at Parma, and we quickly converted that to beds. I believe in June of 1970 we opened it with about fifty beds. Very quickly.

Chall: Was that on the west side where you needed the facility?

Packer: Yes, it was on the west side, where we could not get hospital privileges needed.

Chall: It was already there. That helped.

Packer: It needed a lot of work, and it never was great until we built. And right now we have a very fine hospital there.

Chall: In Parma?

Packer: Yes, on that site. But we did have beds, and we did have an operating room, we did have an emergency room; we had a small fifty-bed hospital.

Chall: And continued, then, to use the University Hospitals and others?

Packer: On the east side, yes. Until October of 1972 when the hospital across the street was opened.

Chall: And what is its name?

Packer: Well, Fairhill is what we call it. It's KFH [Kaiser Foundation Hospital] Cleveland. The one in Parma is KFH Parma.

Chall: When you spoke of Severance, what did you mean?

Packer: Severance is a major shopping center where we looked--Felix Day and others--in 1969, '70, as a possibility of building a major hospital right in that area, in that shopping center area. Site studies and various surveys told us that this was the epicenter of a crescent of growth and, therefore, the hospital would be strategically located there. We ran into zoning problems and community resistance again. Felix Day found this nursing home across the street here. They were willing to sell, and rather than fight the battle of Independence all over again we bought that hospital, remodeled it, and have used it since October of '72.

That is interesting because before buying that nursing home we tried to buy this hospital [St. Anne's, in which Dr. Packer has his office] from the Sisters of Charity of St. Augustine, which is the same order that runs Charity Hospital as well. This was an obstetrical hospital built in the fifties. The nuns refused to sell. They were going to make this a regional Catholic obstetrical hospital.

Packer: So we went ahead and bought the other, and in June or July of '72, when we were well along in the remodeling and getting very close to opening the hospital, the nuns called us and asked us, "Would you like to buy this hospital?" Only a year after they had flatly and finally refused to sell.

We were advised by Karl Steil, Howard Haggerty from the Central Office, who was a facilities person, and others that we ought to grab this hospital. It was a very good buy. We could use it to maybe someday bring our major hospital here, and meanwhile use it for regional OB, psychiatry, and so forth, and inpatient psychiatry. So we acquired it just before we opened the Fairhill hospital, and not long after the nuns had refused to sell it to us.

Psychiatry

Chall: Your psychiatric hospital is inpatient. That is not a usual thing for Kaiser.

Packer: We were very unusual in regard to psychiatric care of any kind, outpatient or inpatient.

Chall: How did that come about?

Packer: The involvement of labor in getting this whole thing started. We started out, on the basis of labor involvement, offering both outpatient and inpatient psychiatric care.

Chall: As part of their fee?

Packer: As part of their standard contract.

Chall: Is that right?

Packer: Yes. There were various co-payments for the outpatient care and there were limitations on the inpatient care. It was limited to thirty or forty-five days, depending on the contract, unlike the general medical and surgical care. We perhaps offered more benefits in psychiatry than any other region at the time that we merged into the program.

Chall: That was just because of the requirements of labor at the time?

Packer: Because of the way the program was set up, and that, in turn, was because of the involvement of labor and their interest in offering these benefits, their interest in alcoholism benefits, and subsequently, of course, in drug benefits.

Chall: So you have kept that up in the same way?

Packer: Yes. I don't believe there's been any substantial change. There have been periodic changes in the outpatient benefits--the number of free visits, the amount of co-pays, the total amount of care available. I don't think the inpatient benefits have changed.

Chall: That meant that you needed to have psychologists and psychiatrists on your staff.

Packer: We have, yes. We started with one psychiatrist and I think one psychologist or one social worker. We added a psychologist and a psychiatrist and it just has grown and grown. Now I think we have six or seven full-time psychiatrists, probably that number of psychologists, and probably that number again of psychiatric social workers.

Chall: That's a major staff.

Packer: It's a major expense. A major requirement, but it was one of the basic requirements when we started.

Chall: Do you have people coming to you from outside the program for your services, these kinds of services?

Packer: In what?

Chall: Psychiatric services. Or you have enough to do with just your own members?

Packer: Oh, I'm sure we have enough to do just within the program, but in psychiatry, as in other services, we had fee-for-service patients.

Chall: They're not in the program?

Packer: We won't turn somebody away because he's not a member. But that person must recognize that the care he will receive will be limited by virtue of the fact that he's in a prepayment group practice. I don't mean that we'll discriminate against him, but he's not going to be able to call up and demand to be seen today, "because I'm paying for it," or whatever. He's just going to have to wait for an appointment like everyone else.

Planning the Facilities

Chall: When you were planning the hospitals and the clinics, how much input did you have, as medical director, into how large the rooms

Chall: would be, and who was going to be in them, and how they were to be scheduled, and all that sort of thing?

Packer: A surprisingly large amount of input. Perhaps not an enormous amount at the time of the conversion of the original Snow View Nursing Home in Parma to hospital beds, because I was new, and because Felix Day was very experienced in that area. But even there, I remember, we had debates, or more, in regard to some of the plans for that hospital. Subsequently, in regard to any facility, we had extensive involvement of the medical group.

In regard to the new construction at Parma--which I think was completed in '72, the first phase--we met for roughly one morning a week for, it seems to me, a year, with the architects. Present would be the health plan people, regional manager, regional facilities guy, the controller; there would be me, the physician in chief on the west side, and any other physicians whose areas were under discussion. We had a great deal of input. It was, I think, a real prime example of joint management on a rather broad scale.

Chall: And it worked out all right? I mean, because of the fact that everybody had a say, it was satisfactory in general to you?

Packer: Well, like everything, it doesn't work out precisely the way you think it will. All in all, it worked out very well, I think. But we ultimately were very dependent on the architect, at times, and we found, for example, before we opened the newer version of Parma hospital that in intensive care the rooms were too small. That wasn't because of a failure on the part of the physicians or administrators sitting together. It was a failure on the part of the architect to recognize the demands for space in intensive care. Since he was an expert hospital architect, this was difficult to accept.

We also found that the partition of the nurses' station was too high to permit easy communication back and forth between doctors and nurses. We discovered this just before the hospital opened and the partition had to be lowered. We found some of the traffic patterns didn't work as well as we had thought. These were relatively small things, and, by and large, we physicians and administrators built a hospital the way we thought it should be built.

Chall: That's a satisfaction in itself.

Packer: Yes, and by and large it worked well and continues to work well.

Chall: It can always be improved in the next facility.

Packer: Yes.

Recruiting the Physicians

Chall: You were responsible for recruiting physicians. Did that take a lot of your time? And how did you go about it?

Packer: A great deal of time, yes. I think the initial recruitment was based on the fact that word of mouth was a great mechanism. Gene Vayda told people that Sam Packer, Sam Freedlander, Bill Young were in, and it attracted some of the younger doctors who were trained where we had taught or were teaching. Other people knew us. And that was the approach we used later. We talked to residents, we talked to friends. Whenever there seemed to be a spark of interest anywhere, we tried to add to the impetus.

We advertised in the usual journals, JAMA, and the New England Medical Journal. We advertised in the Journal of the National Medical Association, the black medical association. I must admit, we did that mainly because of the pressures on the part of EEO [Equal Employment Opportunity]. We advertised in specialty journals. We met at various hospitals. We would have a dinner, just a collegial meeting without formal presentations, rather just dinner and drinks. We would have a couple of brief talks; I would give one, perhaps someone else another, in which we would suggest the advantage of joining the medical group. And that's basically how it worked. Periodically people would apply from another prepaid medical group, or even from within Kaiser Permanente.

Chall: You had to be concerned, though, with the hiring of--or recruiting, I guess is better to say--of certain specialties at various times. If you needed them, and had space.

Packer: Recruitment in Cleveland is extremely difficult. And I say that as a general fact, without qualification. It was far more difficult to recruit in Cleveland than in Denver, certainly than in California, or Hawaii.

Chall: You had your medical school here, though.

Packer: Yes. And that was another source, the house staffs, as I've said. But it was very difficult to recruit. Even though some of us worked at the medical school, even though Cleveland Clinic is down the road and has a large number of house officers, and even though there are a number of major teaching hospitals here, it was very difficult to recruit. For one thing, solo practice was very lucrative; there were no impediments, there were no constraints, and there was no malpractice problem. It was a good time to go into solo practice, particularly if one was willing to make some

Packer: compromises by over-stepping the narrow limits of a specialty and perhaps doing a little general practice, or to work outside of one's specialty.

In addition to that, we did not have a particularly good press. The best press we had was the people in the medical group. We had a professionally well-respected medical group, with Young, and Vayda, and me, at University. As for the other people--Freedlander from Mr. Sinai was very respectable, Peggy St. Clair was University trained, Jim Phillips and all of our pediatricians were University trained. We had a superior medical group. This helped a good deal.

Chall: The Kaiser Permanente name make any difference afterwards?

Packer: Not initially. It made absolutely no difference in our recruitment, in reducing our recruitment difficulties. Not the name. The organization, however, did, because we could offer a better income than we might have otherwise, better fringe benefits, and, perhaps most importantly, a better sense of security than we could offer before. It doesn't do much good to offer a retirement program which pays a lot of money after twenty or thirty years if you're going to be out of business in two or three years. And with Kaiser, obviously, the probablity of survival was greatly improved.

Chall: So, in general, you had problems recruiting; but I suppose in the seventies that was true all over, because fee-for-service, particularly in certain specialties, was lucrative.

Packer: In certain specialties it was true all over. In Cleveland it was true in all specialties across the board. Even in pediatrics, which classically is easy to recruit in because, in HMOs, pediatricians are relatively well paid with relatively limited work demands. Pediatrics is at the lower end of the income potential schedule, generally speaking.

Chall: But orthopedics is high.

Packer: Orthopedics, radiology, they're very high, and surgery and OB are well above the middle. Pediatrics is very low. Even in pediatrics we occasionally had some considerable difficulties. But by and large we were able to recruit there quite well. Dr. Phillips stayed very active at Babies and Childrens Hospital and what used to be the city's hospital, Metropolitan General now. We did well in pediatrics.

We had difficulty in internal medicine for a good many years. It was difficult to recruit, and it was very difficult to get any people trained at the University or the other major hospitals here, particularly University. From time to time we would get one. We got a good many of our internists from outside the city.

Packer: A point of difference that was noted by people like Cliff Keene was that we had what California felt was a disproportionate percentage of foreign medical graduates in this group, including internal medicine. My explanation was very simply that we had much more difficulty in recruiting than California, or Denver, or Oregon, or Hawaii. Much more. And that when we appointed a foreign medical graduate, it was someone whose training had been investigated thoroughly, who was well trained, whose references had been investigated thoroughly, and who we felt was a well qualified physician, despite his foreign medical education.

Chall: Your membership was growing. I don't know whether it grew to the extent that you wanted it to, but you were growing at a relatively good clip. That would make it necessary to have, on your staff, the requisite numbers of medical people. So you had to get them from somewhere.

Packer: Yes, we had to have them, at least in the basic specialties. We desperately needed to get the essential numbers.

Chall: If they weren't here, then, did you use fee-for-service doctors in some specialites?

Packer: We did a variety of things when we lacked full-time physicians. We would get people to come in on a part-time basis. We would get people to come in on an hourly basis. We would get residents to help during their vacations or in the evening. We did whatever was necessry to assure a reasonable availability of providers. In the hard-to-recruit specialties we entered into contracts with individuals or small fee-for-service groups to provide services, like in orthopedics, urology, radiology, or pathology. In some instances the arrangements were a variant of capitation so that we guaranteed a certain minimal payment but basically keyed the compensation to the membership, so that there was a per member per month payment to the contract physician or group.

Chall: Well, you had to learn quickly about capitation, and how you were going to pay.

Packer: Oh, yes, and learning everything. FTEs, about forecasts of FTEs, and about forecasts of dollars, and all these essential things.

Chall: Did you ever find yourself in conflict with the health plan manager and/or the controller over this matter of payment? Of recruiting of membership, of membership fees versus what the doctors felt they needed?

Packer: The person responsible was the regional manager. And did we have differences? Of course. We had differences, and at times they were strong differences, but we discussed our differences. Mr.

Packer: Wyatt and I had differences, sure. But we discussed them. We had some strong differences, as did John Capener and I, similarly. But John Capener was a very experienced manager and very understanding of medical group problems.

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Packer: He was very bright, but also a man of strong opinions. We locked horns on more than one occasion. Sure, there were differences, not infrequently, but they were never disabling or immobilizing differences. We resolved them one way or another. In some areas, I felt that as the representative of the medical group my position had to be fixed, and was absolutely immutable. But much more frequently my approach was that we needed to listen to each other and then arrive at the most reasonable compromise which offered the most to both of us.

Chall: So if they weren't disabling it meant, I guess, that you didn't have to go over the heads of some of these people to the regional manager or vice versa.

Packer: No, I never got into—I felt it important to maintain the integrity of the team definition. But sure, I talked frequently with the health plan manager, or the facilities manager, or the controller (who was also the medical group controller) independently. If it was a matter of major implication, that I should be talking to the regional manager, I would perhaps have this other person in attendance at that discussion. I would not undercut the regional manager by going directly to one of his people and hammering away at that person. That would have put that person in a position of unfair subordination—or call it what you will.

The team approach concept here is, I think, very important. The medical director and the regional manager had to work together. The medical director can work with the other people on the health plan but, basically, only through the office of the regional manager. He should not be by-passing the regional manager to throw his weight directly against the health plan manager.

Chall: Were you able to get minority physicians onto your staff? You advertised, but were you able to find enough of them so that those people who were concerned with minority employment, affirmative action, were satisfied?

Packer: I don't know that they were ever satisfied. I do know we never had any trouble with affirmative action people. At the very beginning one of the nucleus was black, Jim Phillips. Not only at the beginning, he still is. A member of the original group was black; a member of the original group was a woman, Peggy St. Clair. Very shortly thereafter we added Janet Sax, another woman, and we added

Packer: a number of other blacks. I've always been extremely proud of the position we took in regard to minorities. I don't know whether you consider yourself, as a woman, a minority; my wife, I don't think, does. I believe we honestly evaluated applicants on the basis of qualifications and not on the basis of sex or of racial background.

I will also honestly admit that we looked at foreign medical graduates much more carefully, and that, given the choice of equally qualified foreign medical graduates and American graduates, we would have opted for the American graduates because of the need to maintain an American group image. But we added blacks and women regularly. I believe we continue to do so. I believe we also had a greater representation of blacks than probably any other region or perhaps any other comparably sized medical group which was not a black medical group. As far as women are concerned, I believe we always had at least 25 percent to one-third of this medical group represented by women.

Chall: That's a pretty good percentage.

Packer: They have been on the same income schedules, they have had the same benefits, there's been absolutely no deterrent to the addition of blacks and women. We also have Asian-Americans. We have a few Spanish speaking Americans, although in some sense that's a distortion of the fact because a couple of them are Filipinos. I don't quite know where they fall. But they're Spanish speaking, too.

Chall: What about the addition, in the last number of years, of nurse practitioners and paramedics on your staff?

Packer: Oh, it's been more than a couple of years. We added our first nurse practitioner at least ten years ago, probably more than that. I worked a good deal with Ray Kay. I assume you know and have talked to Ray Kay.* He, incidentally, I assume, is still active, and Ray is about eighty now?

Chall: Something like that, right.

Packer: Amazing little man. I talked to him and learned his philosophies, and talked to other people, and we employed them. We've never employed them in great numbers, as Ray Kay did. But we had employed them, and we scheduled the addition of limited numbers of nurse practitioners, not infrequently because of difficulty in the recruitment of physicians. We've added nurse practitioners in lieu of physicians that we could not recruit.

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*Raymond Kay, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985, Regional Oral History Office, The Bancroft Library, Berkeley, 1987.

Chall: In certain fields.

Packer: On a ratio basis of usually three nurse practitioners replacing one physician. I think that's a very standard ratio. Based on the number of patients, on productivity, and total potential productivity, and also on costs.

Chall: Yes, that's a factor. As you, in the last decade or more, have been recruiting more and more doctors from wherever they come from, and, because you started rather long after the Kaiser Permanente program was really established, do you feel the need to carry on the so-called Kaiser Permanente culture—the ideals that were established in the early days of the Kaiser Permanente? That means the history, the so-called desert story, the Grand Coulee story, all of that background which makes people feel that there's something different about being a member of the Kaiser Permanente than any other HMO?

Packer: It's difficult for me to respond to that in totally current terms. In my present capacity—.

Chall: No, but when you were medical director.

Packer: When I was, I would respond in the affirmative without hesitation. We were very pleased to be a part of this organization, a part of this culture—at the beginning because it meant survival. We remained very pleased to be identified as a part of a program which was universally respected, not only as a prototype, but as an example of how to do it well. It's interesting that at times we bewailed our own inadequacies and our own flaws, and emphasized them repeatedly, until we were the recipients of requests for information, or were the hosts of visitors who came and admired what we were doing and told us how well we were doing.

Generally, aside from the anticipated perfectly normal self-flagellation which is part of human nature—to exaggerate one's deficiencies, and fail to recognize one's assets fully--aside from that human failing, I think generally we're pretty pleased with ourselves as a program and feel very much a part of the full program and the Kaiser Permanente culture.

As the program extends to other parts of the country this is gratifying as well, because it makes us a bigger force in the national picture of medical care.

Relationships with the Central Office

Chall: What have been your relationships with the Central Office over the years—with Dr. Keene, for example? How did you work with him and what has been your impression?

Packer: Actually, we medical directors have not worked directly with the Central Office a great deal; that's the health plan office, of course. However, we did work with the Central Office periodically because there were joint problems that had to be dealt with. That was not at all infrequent. And then, of course, the Kaiser Permanente Committee represents a forum for meeting with the Central Office.

Cliff Keene was very easy for me to be around and to work with, very agreeable. And Cliff Keene never forgot that he was first of all a doctor. Also, he was first of all a surgeon. Cliff is a general surgeon too. So that although Cliff practiced no medicine for most of the time he was the health plan president--well, I guess he stopped practicing medicine in the early fifties--he still recognized physician sensitivities and physician motivation and he was, for me, never a problem.

I really had no problems working with anybody. On occasion I had differences with some in the Central Office, but none so deep as to immobilize. I had some differences with Jim Vohs, when he was manager of operations, in regard to some changes he made here in Cleveland.

Chall: What would be some of those problems, just so we can get on the record the sorts of problems that HMOs have or that can come up in the management of those systems?

Packer: There's an essential difference in the HMO--in this particular HMO—between the medical group and the health plan. In the health plan there is a single boss (president of the health plan, or manager of operations, or both), in this case Jim Vohs, who also is chairman of the board. In the medical group, although the medical director is the CEO [Chief Executive Officer], and although in my case I had extended tenure and considerable job security, nevertheless many of the decisions necessarily are made by others than the medical director alone.

The medical director may dominate the decision-making process, but there is a process in which a board of directors or executive committee is involved, and the process occasionally even demands the participation of all partners or shareholders. In other words, the medical director is not an independent operator, who is the boss, like the CEO of the health plan.

Packer: I think the major point of difference that arose between Vohs and me was over the removal of Ron Wyatt as the regional manager here and the appointment of John Capener.

Chall: In what way?

Packer: I felt that--well, Mr. Vohs simply made the changes and then called, advised me, or somehow I learned that Wyatt was going and Capener was coming, without any discussion whatsoever with me or with the medical group in any formal way. I felt that represented, in a sense, a failure to recognize the joint management principle.

Chall: Same old problem?

Packer: Yes. I verbalized this and our executive committee strongly supported my position here. So we had a period of difference there. I think, perhaps, Mr. Vohs felt that if he were to involve me in <u>his</u> decision-making process that I should involve him in <u>our</u> decision-making process. It was my view that there was a total lack of analogy between <u>his</u> position in the decision-making process and mine. That if a medical director were to involve a president of the health plan, like Jim Vohs, in consideration of an election or an appointment in the medical group, it would simply destroy that medical director's position and influence in his medical group. He would be considered a pawn in the hands of the health plan.

Chall: Did you really care about being in on Vohs' decision-making process or just the fact that he didn't tell you that this change was in the works? Was it just a lack of discussing it at all with you rather than being in on who was going to come here?

Packer: I think it was both. I felt that I should have had an opportunity to understand <u>why</u> this decision had been reached, and furthermore have had the opportunity to enter into a discussion concerning the logic of that decision, whether it made good sense from my point of view or not.

Chall: What about the time when Hugh Jones came in after Capener--after what, five years?

Packer: I was very strongly, very heavily involved--

Chall: Oh, really?

Packer: --in that decision to the point of, perhaps, casting the determining vote.

Chall: Vohs was responsible for that decision too, wasn't he?

Packer: Yes.

Chall: Why did he call you in this time?

Packer: I was very deeply involved by Vohs in the decision as to who would replace John Capener, and, as I say, was finally essentially given the option of making the decision between a couple of people.

Chall: Does that mean he bought your argument?

Packer: I don't think he bought my argument. I believe that Jim Vohs, in retrospect, recognized that there would have been absolutely no problem had he discussed with me the reasons, as he saw them, for making these moves. I have always felt that, by and large, I cooperated on the basis of the logic presented and not on the basis of mutual allegiances or antagonisms. I felt subsequently that what Jim Vohs did made sense. I had no way of knowing why it made sense because it hadn't been discussed with me and it was just a peremptory, arbitrary change in management at the top level that very essentially involved me and the medical group.

I don't know that Jim has particularly changed his mind. I've always had the impression that Jim also believed very strongly in the concept of joint management. There are some on the Kaiser Permanente Committee who always believed it more strongly than others, and I thought Jim was one of the strong proponents of that philosophy. Therefore I would be reluctant to say that he learned from that experience.

Chall: He took it under advisement, however, I would think.

Packer: I do know that when John Capener indicated to me that he would like to go back to California, Jim and I talked considerably and repeatedly. As we narrowed down the applicants, in essence, Jim said, "Well, you tell me which of these two guys you think it ought to be," after we had eliminated others.

I would have been perfectly happy without being given the final option; I would have been perfectly happy to sit with Jim and whomever he wanted and make the decision together. The point was, I was a participant at that time, and in the other case I was totally a spectator, which I didn't think—and today do not think—was appropriate.

As I pointed out, Jim's ability to hire and fire was quite different than my ability to hire and fire. Even though Jim and I agreed that I ought to fire someone, I couldn't do it on the basis that we had agreed. I had to work through a partnership agreement or corporate process.

Knowing the Pioneers

Chall: Did you get to know Cece Cutting well as time went on?*

Packer: Extremely well. I got to know Cece extremely well. I discovered that my first assessment that we probably had a good deal in common was accurate, not only as surgeons but as people, and as to what some would call chauvinistic physicians, who despite their chauvinism worked very effectively with the regional managers and the health plan.

Cece Cutting and I became, in addition to colleagues, very good friends. I called Cece whenever I thought his experience would help me with a problem; he always did. Yes, indeed, I had a great deal of contact with Cece Cutting. It was very valuable for me and rewarding on a personal basis. Cece was a very good friend.

Chall: He certainly had been through the fires too, as medical director. He would have understood some of your concerns.

Packer: Yes. Entirely for about twenty years, and before that he was pretty heavily involved. He understood. Every problem, it seemed, he had been through himself.

Chall: Did you ever get to know Sidney Garfield?

Packer: Yes, I knew Sid Garfield. He was not a close friend. I saw him only sporadically, but I knew Sid, yes. I found him to be, as you might anticipate, very interesting, an historically interesting person. He came to Cleveland once. He wanted to see the program here, and he wanted to go to the medical school and meet the dean there, the dean being a Nobel Prize winner. Fred Robbins was one of the Nobel Prize winners for isolating and cultivating the polio virus in the fifties.

We went to the medical school. Sid had all sorts of ideas about using the medical school as an HMO campus. After that he talked at length about the need to recognize the drift of the future and that perhaps this program ought to look at becoming a comprehensive insurer, not only of health care but of all sorts of insurance--you know, essentially a cradle to grave coverage, including health care and life insurance.

*Cecil C. Cutting, History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985, Regional Oral History Office, The Bancroft Library, Berkeley, 1986.

Chall: Amazing.

Packer: Yes, I knew Sid. As I say, he wasn't a close friend, certainly.

Chall: You got to know him.

Packer: Yes, indeed, and to recognize that he was a highly unusual person.

Chall: Did he ever come to try to help with the development of the building, or the planning of your hospitals?

Packer: No, he did not. We had an architect who was a resident architect in northern California until he died, Dave Lepore. And after that we had a private architect who had his own private consulting firm. I think his name was Anton Kohler.

Chall: In a sense, then, you really were given regional autonomy, which is one of the strengths of the program.

Packer: Oh, yes, indeed. I felt we had that all the time.

Chall: How about somebody like Eugene Trefethen, who was the president of the board, who had been here from time to time?

Packer: Oh, yes, I saw a great deal of Gene Trefethen and got to know him quite well. I was impressed, again, that Gene represented one of the reasons that made us proud to be part of this program, because obviously there's big business, there's business power sitting there in all it's splendor, with all its knowledge, and yet it's all directed to dealing with this program, and its strategies, and its needs. It was quite impressive to see Gene sitting there next to Edgar Kaiser.

Chall: How did he seem to you as chairman of the board?

Packer: I sat with the board for every meeting from early '69 through '82. I think his style was quiet, not agressive, but he was quietly in control. The issues had been very largely predigested, and conclusions, I felt, had often been predetermined, so that the committee, the board, rather quickly disposed of its duty. I think Gene Trefethen was in command of the situation because he understood all of the issues and he was prepared to support an issue or prepared to reject an issue with quiet assurance. I just thought he knew what he was doing.

Assessing the Board of Directors

Chall: What has been your impression of the board, of the Kaiser Permanente medical care program, and the central staff?

Packer: Of course, they're separate issues.

Chall: Yes.

Packer: The board has, like most boards, I guess, pretty generally been dominated by the internal membership. Of the internal membership, Jim Vohs, of course, had a great deal of influence on the board. Some years ago Karl Steil had a great deal of influence; Art Weissman was greatly respected by the board. I think Scott Fleming and Bob Erickson are also respected by the board. I speak of respect by not only the insiders but the outside members as well.

The outside members of the board have been of interest. When I joined, Art Linkletter was on the board, and of course he was amusing and entertaining, but not particularly a contributor. He was finally asked to resign by Edgar Kaiser. You know that?

Chall: I think he had some competing interest.

Packer: Yes. Not only a competing interest but competing with an organization of a questionable nature.

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Packer: George Wood, a former president of the World Bank, offered brief, incisive opinions in the financial discussions. His opinions were obviously repected by Edgar Kaiser and Eugene Trefethen.

Chall: Did you have a man from the area here, Vanik?

Packer: Charlie Vanik? First we had Lee Howley, from the area here, who was a very prominent local attorney, and had been on our local board—.

Chall: Of the foundation?

Packer: Right. Helped get things started. Lee was very active in labor circles, as well. He was largely a nonparticipant in board matters. I think he was the usual outside board person who didn't get really involved.

Charlie Vanik followed him. Vanik was a congressman for about twenty-six years, and, I think, the second ranking member of the

Packer: House Ways and Means Committee when Wilbur Mills was chairman. A liberally-oriented guy with a great sense of humor, very articulate, wonderful storyteller. He told occasional stories at the board meeting. And, of course, he interjected comments with political wisdom. He knew the Washington scene, obviously, very well. Yes, Charlie Vanik I think was a reasonably good member of the board for the few years he served.

The Kaiser Permanente Committee

Chall: Well, I suppose that the board that really meant more to you was the Kaiser Permanente Committee, and how did you find that worked?

Packer: I thought it worked quite well. It was very careful to avoid the impression of making program-wide decisions. Periodically it rearticulated its nature as a policy recommending forum for the program, which did not commit to action, and it consistently avoided making operational decisions.

Chall: But was it useful in its advisory capacity?

Packer: I thought so, very useful. I thought it was very valuable. Not only in that conclusions were reached, sometimes the conclusions reached were not conclusions at all but evidence of a lack of unanimity. It demonstrated the opinions of the different regions. The differences between the different regions, the different needs of the different regions, and underlining it all the commonality of all the regions in the entire program.

Many, many discussions focused on regional differences and the need for regions to do things differently, but invariably there was always a final recognition of the fact that the differences must not be so great as to threaten the common thread binding all the regions together. I felt that was extremely valuable, it was very informative, it gave me a forum to express my opinions, to win support, to get shot down, to know what the other guys thought. It gave me an idea, as medical director, not only of what the other physicians thought in the other regions, but of what the nonphysicians thought.

Then, of course, there was the Central Office. The Central Office people had a more global view very often, and the common thread was something they recognized to be very important. I, as a member of a small region, could not have agreed more. I felt that any threat to diversify the nature of the different regions would be threatening to Ohio because we were so small. We simply wouldn't be hanging on the coattails of the big regions if there was great diversification.

The Central Office Versus the Regions

Packer: I'm sure you know that one of the chronic issues that came up in regard to the Kaiser Permanente Committee was the Central Office versus the regions. You've heard of this, haven't you?

Chall: No, I haven't.

Packer: Well, it's strange that you haven't because in the fourteen years I sat on it, to varying degrees, this was discussed. There were entire meetings, practically, devoted to discussions on the realness or lack or realness of that sort of assumption. There were those who felt that the Central Office threatened the autonomy of the regions, and there were those, like me, who felt that the regions could handle themselves, and were not really threatened by the Central Office, and that the Central Office had a major job to do as the central health plan office.

Chall: If you felt that you could handle it, where were the regions that felt that the Central Office was taking over? In what way did they think they were theatened by the Central Office? What did they want?

Packer: Well, I think there were at least a couple of medical directors, three medical directors perhaps, at various times, who were concerned that the Central Office had a great deal of autonomy--controlled the health plan and the regions, controlled all the money, finally, and made the essential decisions.

Chall: Would they have been the older regions, like northern California?

Packer: I don't think Cece Cutting felt threatened. I believe Bruce Sams finds the Central Office somewhat more threatening. I know Hart Baker felt the Central Office, if not threatening, at least frequently adversarial.

Chall: Where is he now?

Packer: He's dead now.

Chall: Where was he?

Packer: Southern California.

Chall: Did he follow Kay?

Packer: Indirectly. It was Kay, and then briefly Herm Weiner, and then Hart Baker. I think he came aboard in '71 or so.

Chall: The problem is that I stopped my basic research at about 1970, so I always like to find out what there is to find out. Some of these names I don't know, yet.

Packer: Herm Weiner was supposed to follow Ray Kay in '71 or '72, and Herm, as you know, essentially self-destructed emotionally. He had to relinquish the position, and I think fairly promptly they elected Hart Baker, who was a good old boy from Arkansas. He really was a good old boy, who lived much, practically all of his professional life in the Los Angeles area. He was a highly respected obstetrician. There was a great deal of affection for him on the part of most of his doctors. He was just a heck of a nice guy, basically.

Chall: I figured maybe the old regions were the ones who had felt strongly about the Central Office. But I don't know.

Packer: I guess Cece Cutting probably had some concerns about it. Cece was in the vanguard of--I suppose you're right, because Cece was in the vanguard of those who organized the regional medical directors into a group that met independently at the beginning of these meetings. So perhaps you are right. Yes, I remember that very well. Cece talked about the need for a--it wasn't a consortium--a confederation of medical directors, I think Cece said. We began to meet independently of the full Kaiser Permanente Committee on the afternoon or morning before the full committee meeting.

Chall: Going over the agenda or your own concerns?

Packer: Both. We felt--and I guess this was Cece Cutting's major point--that if we medical directors looked at the agenda together, or discussed our problems or concerns together, in advance of the meeting, that we would be less likely to be at cross currents, at odds, during the meeting when these issues arose.

Chall: Can you reconstruct what the issues were? I mean, what were the fears?

Packer: Issues frequently were intangible, I felt. Most times they weren't at all clear to me. My participation as a member of the medical director's division, my acceptance of the concept, was based largely on my chauvinism as a physician. I'm a doctor, we have problems unique to doctors--the medical groups--we ought to meet and discuss our unique problems and then, having arrived at some conclusion, that conclusion ought to be presented to the Kaiser Permanente Committee.

Or, we as doctors have a unique view of something that is on the agenda. We together ought to discuss our unique view and see whether it's one unique view or a number of unique views or whether

Packer: they're really dissenting views. And if it is a single view then we ought to be prepared to discuss that. Again, it was a political thing. In union there's strenth, divided we're set-ups for the united Central Office or its equivalent.

Chall: Were they concerned that the Central Office would be determining how the region would be setting up its facilities, or expanding, or deciding on the rate structure? What were they concerned about?

Packer: No, I don't think so. Well, deciding on the rate structure to some degree, because determining rates has always been a kind of iffy proposition--at least when the program was growing well, it was. The medical groups often wondered why the rates couldn't be a little bit higher so there would be a little more money for the medical groups. It was hard to understand until it because obvious that the competion was getting stronger and stronger and the rates had to be very competitive.

I think there was a vague lack of security about maintaining the independence of the medical groups, about assuring that the various fringe benefits would not become eroded, and would improve as rapidly as they should. Or, there was concern that the regional managers, instead of being responsive to the medical directors of the region, first would be responsive, rather, to the Central Office, and then come to the medical director with a predetermined fixed position, and in a sense be negotiating for the Central Office instead of as autonomous, independent regional managers. There were few concrete issues.

I believe underlying it all, perhaps, was the fact that the concept of joint management falls apart at the Central Office level. You see, within the region, at every level there's a joint management team: medical director and regional manager, physician in chief and a facilities administrator, a department head and a nurse in charge. But when you get to the Central Office, there's a president of the health plan, and perhaps his manager of operations, but a blank on the medical group side.

In many, many of our medical director meetings we discussed this: How are we going to deal with that gap? We just lose out at the Central Office level. There's no physician representation there; each one of us goes there independently, and then some medical directors do better than others. So the idea was that we needed someone at that level.

But how do you get someone at that level? We finally had a medical directors' committee and a chairman. But is a chairman of that committee going to take up residence in Oakland for a year? Obviously not. I would be the first to say no. Well, how are you going to do it? Are you going to get a doctor, just appoint a

Packer: doctor, elect a doctor, to represent all the regions there? Then, how are you going to get someone worth a hoot to do that? It's going to be very difficult.

We finally got around to the appointment of Dr. Paul Lairson, of whom you may have heard, who we recognized was respected by the various medical directors. He was a man who was a doctor and felt himself a doctor, and would communicate with all of the medical groups as necessary, and on behalf of all the medical groups as necessary, and on behalf of all the medical groups with the Central Office, and from the Central Office to all the medical groups, or to the chairman of the medical directors' committee. Paul Lairson, in a sense, now fills that void.

Chall: But it's just on an allowable basis; there's nothing structured about it?

Packer: Oh, yes, it's quite structured.

Chall: Oh, it is? What kind of title does he have?

Packer: I've seen it recently, but I'm not sure. I could tell you in a moment. [looking into file] No, you will have to look it up because here he's simply shown as a medical advisor KPAS [Kaiser Permanente Advisory Services], and that, certainly, was not his final assignment.* I think, perhaps, to some degree, Paul has allayed some of the suspicions and insecurities.

Chall: I can see how they might arise. Wouldn't the regional managers have also been just slightly concerned about their own prerogatives or authority as regional managers? But, since they're appointed by the Central Office, they may have more loyalties to the Central Office than to the region.

Packer: You raise a point which was raised frequently by the medical directors: Would their primary allegiance not be to the Central Office rather than to the region? Would their desire to satisfy not be greater towards the Central Office, which determines their incomes, than towards the regions? Yes, that certainly was a part of the concern.

And in my opinion, that varied enormously, individually. Some regional managers were very independent and called upon the Central Office very infrequently, except for routine support kind of help, while others were--we medical directors felt--probably on the phone every time they had to make a decision.

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*Paul D. Lairson, M.D., Physician Liaison, Permanente Medical Groups.

Meeting the Competition from Other HMOs

Chall: Before you retired, were you beginning to see competition from the other HMOs coming up, and what was this doing to your region?

Packer: You mean locally or nationally?

Chall: Locally. Was your membership falling? The numbers weren't falling, but was the rate falling enough to concern you?

Packer: Yes, we were seeing competition. I don't know that we felt that the rate was falling mainly because of the competition, but yes, we were recognizing there was a competition that was real, that we had to deal with. During my last five years or so we tried to develop some strategies to deal with that.

Chall: What would they be?

Packer: For a good many years my opinion had been--and I believe it was shared by the region generally--my opinion was that we should follow the pattern of northern California as contrasted with southern California, in expanding. That we should expand with major centers only, not small, detached offices as they were doing in southern California.

Chall: A major center means a clinic with a hospital?

Packer: Ordinarily, or at least a reasonably large clinic. In southern California they had a fair number of free-standing offices.

Chall: Where did you go, where did you expand here?

Packer: Originally we, as I say, followed the northern California pattern. Then, as the competition began to stake out franchises in the outlying suburbs, it became clear--and I had to accept it, finally, after refusing to for a good many years--I had to accept the fact that we had to get out into those outlying regions or we were simply going to lose them to the competition.

So we developed plans for a series of what we called SMOs [Suburban Medical Offices] which would start, maybe, with three or four doctors and then, as originally planned, expand up to maybe a dozen doctors, or perhaps in highly unusual circumstances, to twice that many. We developed about half a dozen of the Suburban Medical Offices.

Chall: And what about your hospital facilities? Generally speaking, weren't hospitals integrated with clinics in the Kaiser plan?

Packer: Yes. Well, obviously the Suburban Medical Offices have got to have inpatient facilities. Some of them, which are reasonably close to either this place or Parma, send their inpatients to these hospitals, but those that are relatively remote use local hospitals.

Chall: That's a change.

Packer: Yes, a dramatic change. And indeed there were some problems, because there was an interface which was not strictly defined, determining theoretically whether people on this side came here, for example, or went to an outside hospital. Sometimes people well on this side of the interface would go way out to the office out in Lake County, which is well east of here, because they wanted to be hospitalized out there rather than here. That created some problems, at least initially.

Chall: But you worked it out?

Packer: I don't think it ever will be worked out completely.

Chall: But the decision was made not to build your own hospitals?

Packer: Well, that decision was a very easy decision because we simply didn't have enough membership out in any generally discrete area to permit consideration of building a hospital there.

Chall: So you had to revise the so-called genetic code. That had to be changed. I think in Denver they never have felt obligated to comply with it.

Packer: I think they did several years ago.

Chall: They dropped it.

Packer: Due to community pressures they dropped it, just as we did here, when we abandoned the plan to build on this site and instead entered into a contract with the St. Luke's Hospital.

Chall: That seems to be working out?

Packer: Well, I hope so. It's only a couple of weeks old. It's a little early to draw any definite conclusions.

Chall: But the health plan is to move into the suburbs?

Packer: It has moved into the suburbs, a western suburb and an eastern suburb and a southeastern suburb, oh, five, six, seven years ago. and it's moved into several other suburbs since, and it will be moving into Akron, which is about thirty-five miles away.

Chall: Oh. Well, that's another city. That's not a suburb.

Packer: Yes, that is not a suburb. That'll be a totally independent operation. You must understand that at the very beginning, when the first medical service agreement between Kaiser and the medical group was written, one of the issues was to what territory the medical group would be restricted. Would we be prepared to serve the health plan if it developed an operation in another part of the state? We weren't sure.

So the agreement was that we would get the choice of the first refusal for any expansion of this program in the state of Ohio. If we refused to participate, then the health plan would be free to enter into a contract with another medical group. Akron, obviously, represents an expansion where we do feel willing and able, and anxious, to provide services.

Chall: Why has it taken so long to move into a major community like Akron?

Packer: One of the early reasons was that we had tough times at the very beginning. When we became part of Kaiser we were distinctly in the red for several years, and we stayed in the red. The idea of moving elsewhere and starting another deficit operation while this one was very much in the red didn't seem reasonable.

Subsequently, we looked periodically at other major cities, including Columbus, but always there seemed to be an economic downturn or something, which distracted us from proceeding. Also, the competition wasn't all that great at the time. When the competition began to surface, first it hit right near home, as our competitors, including even Blue Cross, began to stake out the suburbs where most growth was anticipated. We decided we would give them some competition in those areas.

Chall: So the others have come around more slowly. Well, that's for somebody else to do.

Packer: Well, as some came around more slowly others have gotten into those areas around as well. There are several HMOs in Columbus. In my opinion, that is still a viable possibility, but the decision, apparently, has been made to go to Akron instead.

Chall: How do the HMOs look to you in terms of their future and the competition with Kaiser? How do you feel Kaiser's going to come out in all of this?

Packer: Again, I have to plead relative ignorance. I can respond largely in terms of what I have felt before. As I said earlier, we were an imperfect organization, distinctly so. We have a fair number of flaws and blemishes. However, we do get the job done and, as we

Packer: look around, we get it done better than just about anyone else. I just fail to see how an operation that is public, and dedicated to profit, can fail to compromise on the quality of what it's doing if it becomes economically advisable to do so.

On the other hand, let me put it differently. I'm inclined to speculate that some of the relatively large for-profit operations, and probably a lot more of the small ones, are interested in what we might call a relatively quick buck. They're going to make a profit, and as soon as the ability to make a profit dissipates, they've got no reason for staying in business. Their primary business is making money; our primary business, really, is not making money. There are no public shareholders or stockholders. Any cash generated by this program flows back into the program.

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Packer: Money that might accrue to the medical group and to the individual physicians is relatively small, sometimes very small. The cash generated goes back into the program. It goes back into more facilities, more equipment, more personnel, or lower dues with the same or higher level of services. Well, that's so dramatically different from the for-profit operations that, ignorant as I am of the subtleties of the business world, it seems to me there's incompatibility between these two systems based on the profit motive.

Chall: Are you concerned about their quality of care, or that maybe the Kaiser quality of care might even go down in any way while this era of competition is so strong?

Packer: I suspect that should always be a concern when there's a great deal of competition, and I suspect that it's a concern that should assure that the quality of care doesn't go down. It seems to me that, finally, the most effective way of dealing with the competition is to outdo it. Dealing with it simply by undercutting it in terms of dues will go only so far, because if a program gets a bad reputation as being of poor quality, I suspect that in the matter of your health and your life it will not be very attractive any longer. You may be willing to buy a cheap car with a poor reputation because it's all you can afford--you take your chance on that--or you may get an inferior disposal, or clothes, but your life and health are a different matter.

We are well aware that the thing that motivates people most is money, and that in selling this program the first thing many look at is what it is going to cost. But for the competition to remain effective, finally, it has got to offer a product which isn't so bad that people don't say, "That costs less, but it's dangerous to buy it." It's like the Pinto. That was a low-priced car, but I wouldn't have bought one on the basis of what I heard about it.

Assessing the Medical Program

Chall: You've mentioned that you have been concerned, over the years, about the flaws in the program. I wonder if you would just list what you think have been your flaws. I would like you to list those--you probably have in some speeches or other, but maybe you haven't--so we can see what they are. Because this is for the record, historically, people will want to know how one like you assesses the program.

Packer: It's very important, in discussing flaws, to recognize that this is a bicameral program and one component is always looking at the other component. So, we the physicians see flaws in management on the health plan side; we see a lack of concern with quality, with medical quality, on the management side. This intermittently has surfaced for many years.

Chall: How does it show itself?

Packer: Physicians may say, "They just don't give a hoot about quality of care; we don't have the necessary equipment," for example. "We don't have the state-of-the-art equipment. We don't have enough of the state-of-the-art equipment. We don't have enough providers; we don't have enough doctors, or physician equivalents. We don't have enough support for the doctors, the doctors have to do things that some support person ought to be doing.

"The phone system isn't adequate; our patients can't get through to us. Or, our patients get through to us too easily. The appointment system isn't adequate; people who are real sick can't get in, people who aren't sick keep coming in every week. They can't handle the load. People are refused appointments when appointments are available. Providers aren't given an opportunity to try to arrange an appointment requested by a patient when the physician knows that patient and, had he known the patient called, would have made special arrangements to see the patient." Et cetera, et cetera.

Chall: Is management not providing you with enough staff, is that it?

Packer: That's part of it, certainly.

Chall: That's in addition to equipment.

Packer: Yes, physicians say, "Inadequate staffing, inadequate equipment. Inadequate concern with quality totality. We have difficulty in the recruitment of physicians because we're not competitive with the outside market. We underpay our physicians. We overwork our physicians. We don't recognize income potential between the various specialties."

Packer: "The health plan projections are usually grossly inaccurate. We frequently are understaffed because of the health plan projections." This, I believe, may be an archaic argument now, because health plan growth isn't that rapid. But when it was rapid, this, I believe, was a frequent argument: that the health plan chronically underestimates growth, and therefore we are regularly understaffed, not only understaffed but the facilities are inadequate to serve the demand.

In terms of facilities, at one facility or another it will be alleged that the administrator doesn't care how the facility looks, doesn't keep it clean; that the furniture is all worn out, it's an unattractive facility; that there's not enough room in the facility. All that sort of thing.

And when you get to the regional manager, the complaints are, "The guy doesn't care about this region, really. He's not running this region. Every time that there's a question or problem he gets on the phone and he's calling that Central Office. Or the Central Office will call him and tell him what it wants to do in his region."

You know, what I describe are the sorts of things that, at one time or another, in every region, probably have been heard, and which will resurface periodically just as any bad thing periodically recycles and reappears.

To put it a little differently, not everyone is <u>always pleased</u> with the way the program works, and with the way he can work within the program, and with the way he is compensated for what he is doing. This I describe as flaws and imperfections.

Perhaps I would better describe it as this program's being susceptible to the vagaries of human nature, just as any other program is. And to indulge myself in similar sterile comparisons, the grass is greener on the other side of the street. Things are always better somewhere else than where they are. Until you get somewhere else. And then it is very surprising how frequently our physicians, who have gone somewhere else, come back. Or how frequently they would like to come back but we don't want them back. Or how frequently they look into other parts of this program, or similar programs.

Chall: So what you're describing are problems that you always had from time to time, but they're problems that other people saw as more serious than you might have.

Packer: Well, they are problems that we have seen here, and I have heard them expressed in other regions. But the fact is that when people come to see us, they are not impressed that these problems exist, or that they have any significance. On the other hand, they are

Packer: impressed that we are doing a very effective job, of very good quality, and that we are provided with good support and first-rate facilities. Visitors, almost invariably, come away positively impressed--whether they come from the academic world, or developing HMOs, or even competing HMOs.

Chall: So some of these problems are in the nature of the beast.

Packer: I think so. I think that without any question they are in the nature of the beast, and they fail to recognize that nothing is perfect. Nothing seems perfect to whoever's got it at the moment.

Chall: Whoever feels slighted. And I'm sure all of these problems have ocurred. It must have been your job to see that your physicians were satisfied, because most of what you were telling me are concerns on the side of the physicians and members.

Packer: Yes. Well, members, of course, opt out if they're unhappy.

Chall: Accessibility is a problem.

Packer: Accessibility. We always griped about the availability of providers to deal with members once they got in. The problem of support that was necessary to assure the continuity of care was a problem at one time or another.

I think those of us who, like me, have labored for a while in the vineyard of solo practice are less inclined to be upset by some of these so-called imperfections. We recognized that the quality of what we do was enhanced by virtue of the fact that by and large we all see what we all do. A bad apple is pretty quickly identified and the incompetent or possibly incompetent is brought to light very quickly, simply because we work together so intimately.

On the other hand, in a solo office, what goes on is completely the business of the individual. And in a small fee-for-service group, the compromises made are completely the affairs of that very small number of people.

Chall: That's an aspect of the panel medicine that we didn't discuss, because I guess we just assumed that one of the important aspects is that you are open to watch each other. It's essential.

Packer: Yes, I know. I have called it practice in a fish bowl. Everyone can see what you're doing. Not only do they see it when they work directly with you, but they see it when a patient comes in to see them whom you have seen before, and they refer back to your notes, and your care, and see rather quickly whether it appears reasonable or not. It's quite different from working in much of the fee-for-service world.

Packer: One of the problems that we have had historically in the community hospital has been the unwillingness of the professional staff to monitor itself and discipline itself. Part of it's been political, and more of it, probably, has been economical. If you're to hold office at such a hospital you can't be disciplining the people of the electorate, particularly if your term is one or two years, which is often the case. If you are a person who is dependent on referrals, it's going to be extremely difficult to impose penalties on referring physicians, because they may be offended and send their work elsewhere.

Chall: Were there many physicians in your career here who had to be removed from either the partnership or removed before they became partners? Is that a two-year stint?

Packer: Yes, the probationary period is two years, and always has been. No, there have been very few. I won't pretend that our physicians universally are of the most superior quality. I think we follow a fairly average distribution. We've got, and always have had, some extremely good people, and, at the other extreme, some who just plod along to get by. Most of our doctors probably fall somewhere in between, which is generally true. We have no monopoly on talent.

Fortunately, I believe, there's a greater density on the talent side of the curve than on the other side of the curve. On the other side of the curve, if there is a real lack of confidence, we make it clear--indeed, we invite such a person to consider an alternative way of practicing medicine. When they fail to recognize that, we have, on rare occasions, had to ask them to leave. The people on the extreme opposite to the talented side, I believe, are few in number and are not dangerous.

Chall: I suppose there are some physicians who come in and then find that this type of practice, where everything is open to their peers, is maybe not what they like. They may opt out voluntarily although they may be good physicians.

Packer: I don't think so. I think the good physician doesn't opt out because he's concerned about his visibility. He opts out, I think, for other reasons, like seeing more income potential out there, like academia being more attractive, like getting a more appealing offer from a different group. Or like simply wanting to move to another part of the country, like Hawaii, or California, or Colorado. That's been perhaps the most frequent cause for relocation.

I think that the person who is most likely to feel unhhapy with visibility--which is a requisite in a program like ours--is either the person who is marginal or the decent physician who just is very insecure in regard to what he does, no matter how well he

Packer: does it, and doesn't like to have people looking at what he does. There are some people who are basically entrepreneurs, independent operators. They can't tolerate any sort of imposed constraint or any sort of routine which is obligatory. They're the sort of people who move along.

Activities in Retirement

Chall: Tell me what you're doing now as Operations Consultant and Director of Special Projects? What does that mean?

Packer: I'm not sure, after three years, exactly what that means. You ask about my post-retirement activities.

Chall: Yes, that's right.

Packer: I haven't been considering myself retired.

Chall: Well, no, not if you're working here practically full time. Maybe this title doesn't mean anything?

Packer: I was full time through '85, and I continued to do a little surgery until January of '86. Unfortunately, that is now out, at least for the present. As director of special operations, I have been asked periodically to take a problem and work it out; to get opinions in regard to some issues, which I'm able to do because in the course of my years of practice, training, and medical school, I've gotten to know much of the medical community, and I'm able to get on the phone and get information from a lot of people.

Chall: What kind of projects and problems would you be trying to check on?

Packer: It may be an internal problem; it may be one which is community-wide, or profession-wide. For example, I have worked on the problem of palato-uvulo-pharyngoplasty, which is an operation for snorers and people with sleep apnea. I have dealt with weight reduction surgery. That's another problem I worked on. Mammoplasty is another problem. These sorts of things.

Within the program there have been matters such as the comparability of time spent on similar services by providers in different areas of the program. There have been periodic surveys on my part, or analyses of the requests for changes in compensation by some departments. And, in general, anything that the medical director has problems with.

Chall: My goodness, that runs the gamut.

Packer: Yes. Right now, for example, he's asked me to find out what the various specialty boards may require in terms of waiting to qualify to take the certifying examination, and what the waiting periods for an examination may be, because there appears to be a trend on the part of some to require that all medical group members, at least in the future, be appointed only with board certification, and that sort of thing.

As operations consultant, any time people have problems they want to discuss, they come in and sit down and I tell them what I know. Occasionally, in a few minutes I can give them the answer to something that's been bothering them. Not because of my innate brilliance, but simply because--

Chall: You've been around.

Packer: I've been around, yes. I've been there, and I know what happens and what happened.

Chall: I think that's the value of a senior remaining on staff, because so much of what we know is inside of us.

Packer: That's right. I think it's unfortunate that there's a failure to utilize it better, but then I guess all of us who phase out of a very active and very important job kind of feel that there ought to be a better way of being used now. I also have not given up entirely on doing something different with my life at some point.

Chall: Do you have or have you ever had hobbies or activities outside of medicine?

Packer: Not really. I was in a real sense a bachelor when I got married--well, I guess we all were--but I was older than usual. I was thirty-five when I got married and rather surprised to find myself the father of my first child eighteen months later! But, as things evolved, I found that my family assumed an importance and a role which I hadn't fully appreciated as a bachelor. You know, marriage and that sort of relationship always seems to be for someone else. Certainly the focus of my extra-medical life has been around my family. I'm not a golfer, I don't play cards, I'm not a jogger. I walk my dog.

I told you that some of my kids want to write more than anything. Actually, I think probably all but my youngest want to write more than anything. Certainly the oldest three do. And I think that somewhere along the line I've got to do that. After all, I did minor in English a long time ago. I would have preferred to major in English, but I thought I needed to major in psychology because, you'll remember, I wanted to be a psychiatrist. I've been accused of indulging myself with this desire to write through the volume of the memos I turned out over the years.

Chall: Is there a possible history of this program that you would write?

Packer: Yes, certainly as far as the local program.

Chall: Yes, definitely just the local.

Packer: And to some degree in regard to its relationship to the Kaiser Permanente Committee and the Central Office, and some of the people you have named, yes. I've suggested that.

Chall: Some of the doctors have done that.

Packer: I've suggested that to our board, and apparently they're reluctant to make the time and resources available. And being as independent as I think I ought to be, I have been reluctant to push it. Our board of directors suggested that I ought to write a brief history and not spend too much money on it. My response was that if and when I do write a history, it will have to be on my own, because I will have to feel free to write as much and research as much as I feel is necessary. So, the history writing as a program activity at the present time is out. If it is broached again, I will be happy to proceed, given the opportunity to do it on a scope and scale that seems reasonable.

Chall: Maybe something like this will be an inducement--the oral history.

In terms of your own personal relationships, were most of your friends and your social activities with the medical people here? You had already established some, I'm sure, because you've lived here all your life, so that you wouldn't have narrowed it necessarily to the medical group.

Packer: It did narrow it a great deal, sure. We're twenty-two years old, now, as a program, or will be in July. Yes, my friends largely are from the group or from people who in some way are related to the group. Of course, we have other friends, we have other activities, but I suspect that most of the people I call my friends are from within the program. Not only the group, but non-physicians in the program I've also gotten to know and enjoy.

Chall: There's always more to talk about, but I think that after nearly six hours sitting at your desk talking to me, you must be talked out. We seem to have covered the outline. Thank you very much for a candid and most interesting interview.

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*Unless otherwise specified all place names are California. KPMCP refers to the Kaiser Permanente Medical Care Program.

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Wage Rate Analyst with the Twelfth Regional War Labor Board, 1943-1945, specializing in agriculture and services. Research and writing in the New York public relations firm of Edward L. Bernays, 1946-1947, and research and statistics for the Oakland Area Community Chest and Council of Social Agencies 1948-1951.

Active in community affairs as a director and past president of the League of Women Voters of the Hayward Area specializing in state and local government; on county-wide committees in the field of mental health; on election campaign committees for school tax and bond measures, and candidates for school board and state legislature.

Employed in 1967 by the Regional Oral History Office interviewing in fields of agriculture and water resources. Project director, Suffragists Project, California Women Political Leaders Project, and Land-Use Planning Project, and the Kaiser Permanente Medical Care Program Project.